

FINAL EVALUATION OF THE
USAID/BOTSWANA
POPULATION SECTOR
ASSISTANCE PROJECT (BOTSPA)

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by

William Trayfors
Cynthia Green
Gerald Moore
Millicent Obaso
Waneen Polly
Mary Wright

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Edited and Produced by

Population Technical Assistance Project
1611 North Kent Street, Suite 508
Arlington, VA 22209 USA
Phone: 703/247-8630
Fax: 703/247-8640

E-mail: poptech@bhm.com

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LIST OF ABBREVIATIONS

| | |
|---------|---|
| ACT | AIDS Action Trust |
| AIDS | acquired immunodeficiency syndrome |
| AMC | Activity Management Committee |
| AMMB | Association of Medical Missions for Botswana |
| ARI | acute respiratory infection |
| ASU | AIDS/STD Unit |
| BFTU | Botswana Federation of Trade Unions |
| BNPC | Botswana National Productivity Centre |
| BOCCIM | Botswana Confederation of Commerce, Industry and Manpower |
| BOCONGO | Botswana Council of Nongovernmental Organizations |
| BOFWA | Botswana Family Welfare Association |
| BONASO | Botswana Network of AIDS Service Organizations |
| BOTSPA | Botswana Population Sector Assistance Project |
| BRCS | Botswana Red Cross Association |
| BSMP | Botswana Social Marketing Program |
| BWC | Botswana Women's Council |
| CBD | community-based distribution |
| CCC | Cambridge Consulting Corporation |
| CDC | Centers for Disease Control and Prevention |
| CHN | community health nurses |
| CMS | Central Medical Stores (Ministry of Health) |
| CPR | contraceptive prevalence rate |
| CSO | Central Statistics Office |
| CTS | Central Training Section |
| CYP | couple year of protection |
| DHT | District Health Teams (Ministry of Local Government, Lands and Housing) |
| DMOH | District Ministry of Health (staff) |
| EPI | Expanded Program on Immunization |
| FHD | Family Health Division |
| FHS | Family Health Survey |
| FWE | family welfare educators |
| GOB | Government of Botswana |
| HEU | Health Education Unit |
| HIV | human immunodeficiency virus |
| HSU | Health Statistics Unit |
| IEC | information, education, and communication |
| INTRAH | Program for International Training in Health Project |
| IPPF | International Planned Parenthood Federation |

| | |
|---------|--|
| IUD | intrauterine device |
| KAP | knowledge, attitudes, and practices |
| MCH/FP | maternal and child health/family planning |
| MFDP | Ministry of Finance and Development Planning |
| MIS | management information system |
| MLGLH | Ministry of Local Government, Lands and Housing |
| MOE | Ministry of Education |
| MOH | Ministry of Health |
| MOH/FHD | Ministry of Health/Family Health Division |
| MOH/HRU | Ministry of Health/Health Research Unit |
| NCPD | National Council on Population and Development |
| NGO | nongovernmental organization |
| NPA | Nonproject assistance |
| OC | oral contraceptives |
| OHU | Occupational Health Unit |
| OR/TA | Operations Research/Technical Assistance |
| PHN | Population, Health and Nutrition |
| PIACT | Program for the Introduction and Adaptation of Contraceptive Technology |
| PID | project identification document |
| PP | Project Paper |
| PRG | Project Reference Group |
| PSI | Population Services International |
| RH | reproductive health |
| STD | sexually transmitted disease |
| TA | technical assistance |
| TFR | total fertility rate |
| TOT | training of trainers |
| TRG | Training Resource Group |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations International Children Emergency Fund |
| USAID | United States Agency for International Development |
| WEDs | Worker Educator Distributors |
| WHO | World Health Organization |
| WRA | women of reproductive age |
| YWCA | Young Women's Christian Association |

EXECUTIVE SUMMARY

The Botswana Population Sector Assistance (BOTSPA) Project began in July 1988, was redesigned in September 1992, and will be concluded in September 1996. The purpose of the final evaluation of the BOTSPA Project was to examine the progress-to-date in implementing the project since its redesign in 1992, and to provide insight and guidance for future programming by the Government of Botswana, the United Nations Population Fund (UNFPA), and other possible donors.

The evaluation team found that the BOTSPA Project has made an important contribution toward the strengthening of reproductive health services in the country, although the project has not achieved all of its objectives due to delays in contracting. Much good work has been done, particularly in training, condom social marketing, and operations research. For a variety of reasons, including those extraneous to the project design and implementation, BOTSPA was unable to reach all its goals within the life-of-project period.

The objectives of the redesigned BOTSPA Project for the years 1992 - 1996 were to

- ? Strengthen the public sector reproductive health services, in particular, family planning (FP), and sexually transmitted disease (STDs)/HIV/AIDS prevention;
- ? Launch a social marketing program based upon wide availability of low-cost condoms and upon education and information on STD/HIV/AIDS prevention; and
- ? Strengthen management and technical capacity of local nongovernmental organizations (NGOs) in HIV/AIDS-prevention activities.

The programs begun under the redesigned BOTSPA Project have made considerable headway toward better reproductive health and should continue after the end of the project period.

Though relevant information was incomplete, from the data that was available it appears that the level of use of the three most effective contraceptive methods that are generally available in the Botswana national MCH/FP program (intrauterine devices, orals, injectables) has not increased significantly, if at all, over the years 1988-1996. By contrast, use of condoms has grown rapidly in the face of the present HIV/AIDS crisis. Information on dual-method use and on the fertility impact of using condoms alone is lacking.

If the detailed recommendations that the evaluation team makes in this report which are

implemented, it should help the Government of Botswana, and the Ministries of Health and Local Government, Lands and Housing in particular, to achieve several things: (a) consolidate achievements in family planning and HIV/AIDS prevention over the past decade; and (b) lay the basis for further gains. National leadership and advocacy continue to be of primary importance.

Of particular importance is the need to strengthen efforts to extend family planning promotion and STD/HIV/AIDS prevention activities into the community. A summary plan of action to carry out an intensive district-level initiative has been developed by the evaluation team and is attached (Section 7 and Appendix J). This initiative should be implemented first in one district, with careful planning and preparation, and should serve as a model for similar initiatives to be replicated in other districts.

Financially, the project underspent its budget by some US\$500,000. This was due largely to the late start of several of its activities, some of which have had only nine months to run. It is recommended that the remaining funds be transferred quickly to the Cambridge Consulting Corporation (CCC) contract to support immediate technical assistance (TA) and commodities needs identified during the evaluation.

Recommendations have been made for UNFPA assistance (and possibly other donors) in high-priority areas to continue the work started under BOTSPA.

Following is a summary of the strong and weak points of BOTSPA and of the larger maternal and child health and family planning (MCH/FP) program, a graphic summary of overall findings with regard to reproductive health program performance, and a summary of recommendations.

Strengths

1. Despite mis-starts and delays, the BOTSPA project has made important contributions to the development of reproductive health services in Botswana. Of particular importance are the upgrading of skills of MCH/FP service providers, the Condom Social Marketing Program, operations research, and the initiation of activities with several NGOs.
2. The Botswana MCH/FP program has many strengths and has helped to achieve moderate levels of contraceptive prevalence.
3. A Family Health Survey (FHS) is under way which will help document changes in contraceptive prevalence and contraceptive mix since the last FHS in 1988.
4. Most Ministry of Health (MOH) and Ministry of Local Government, Lands and Housing (MLGLH) facilities offer MCH/FP services, and most have personnel and supplies and equipment needed to carry out these services.

5. Population coverage of fixed and fixed-mobile facilities is pretty good, i.e., services are theoretically within reach of most of the population of the country.
6. The MOH is actively considering ways in which to strengthen community-based programs, working through NGOs and the private sector, thereby making information and services more accessible by those in need.
7. A recently completed Situation Analysis has pointed out numerous weaknesses in the present service availability. The MOH, MLGLH, and other branches of government appear to be taking these findings seriously, and are looking for solutions.
8. Important policy changes are being made with respect to access to family planning services and removing barriers to service provision to couples in need.
9. A comprehensive Population Policy is in draft for promulgation in the next five-year plan period (beginning April 1997). This policy is to be followed by the development of strategic implementation plans in each sector.
10. Batswana who are involved in the reproductive health (RH) program are justifiably proud of their accomplishments thus far, but recognize that many problems remain.

Weaknesses

1. Weaknesses in the Botswana national MCH/FP program remain in service availability, quality, and accessibility. Chief among the weaknesses are the following:
 - a. inadequate outreach to help maximize utilization of existing facilities and meet client needs;
 - b. insufficient numbers of service providers in the fixed and fixed-mobile facilities;
 - c. insufficient pre-service training in RH for existing staff;
 - d. a persistent pattern of disruptive staff transfers;
 - e. deficiencies in quality of reproductive health services provided;
 - f. inter-ministerial coordination problems, especially MOH-MLGLH;
 - g. little effective supervision (especially supportive supervision);
 - h. lack of strategic and operational plans to address program deficiencies;
 - i. a tendency to think of activities piecemeal, rather than as key component parts of an overall strategic plan;
 - j. a near total lack of information, education, and communication (IEC) strategic planning and use of multimedia channels, especially in support of service delivery; and
 - k. insufficient attention to issues of financing and sustainability.

2. The decision by the United States Agency for International Development (USAID) to terminate assistance to Botswana is awkward for meeting program objectives under the BOTSPA Project. Just as many activities are gaining momentum, support is being withdrawn before they can fully take root. These activities mainly address some of the serious deficiencies listed above.
3. Botswana's reproductive age population is undergoing a devastating crisis as a result of HIV infection. With an estimated one-third of pregnant women infected, and prevalence rates still on the increase, it is difficult to foresee the character and dimensions of the eventual (negative) impact of the epidemic on overall health, social, and economic trends.
4. Worse, the reported sexual practices in the country tend to intensify the risk of spreading STDs and HIV throughout the reproductive age population, and to newborns of HIV-infected mothers. A beginning has been made in condom distribution and in youth education, but much more remains to be done if HIV sero-positive prevalence rates are to be curtailed.
5. At best, these trends will necessitate significantly increased MOH spending on hospital and home-based care for a growing population of infected persons, further taxing manpower availability for preventive programs such as reproductive health. Yet continued investment in preventive programs must be vouchsafed if the negative trends are to be reversed.

A summary of the team's findings regarding overall reproductive health performance follows.

Insert RH Scorecard

SUMMARY OF RECOMMENDATIONS

Management and Planning

- ? The Ministry of Local Government, Lands and Housing (MLGLH) and MOH need to develop a clear vision and strategic plans for complementary, district-centered family planning and STD programs to operationalize population policy strategies.
- ? Since services are delivered at the local level, district health managers (district health teams and MOH) need to be the focus for developing and implementing operational plans for the family planning and STD Program.
- ? The level of authority for reproductive health/family planning in the MOH needs to be raised within the organizational hierarchy to give sufficient attention to priority reproductive health, family planning, and STD/AIDS needs. Similarly, the Ministry of Local Government, Lands and Housing needs to give appropriate emphasis to reproductive health in its management structure.
- ? A supportive supervision process carried out by the District Health Teams and MOH supervisors at each site should be adopted. The ?Triple-A Supervision Initiative? being carried out by the MLGLH and MOH with the support of UNICEF, offers a model of self-directed assessment, analysis and action that should be considered.
- ? The future role, responsibilities, and objectives of the Central Training Section (CTS) need to be clarified and agreed. It is the judgment of the evaluation team that overall responsibility for the reproductive health program in the MOH would not be an appropriate role for the Central Training Section, but rather it should continue to be responsible for the FP/STD training.
- ? Program strategies need to take into account the disruptive effects of the continuous changes in staffing due to transfers, local training, and long-term external training.

Training

- ? Training capacity should be expanded in order to train all service delivery nurses and nurse midwives and their immediate supervisors to deliver integrated family planning and STD/HIV counseling and services.
- ? The intensity of family planning and STD/HIV training in the preservice nurse and midwifery curricula should be heightened so that all new nurses can practice fully and confidently upon completion of their programs. Nursing tutors at the Institutes for Health

Sciences should participate in the FP/HIV/STD intensive course described below to emphasize the importance of strengthening the preservice curricula with integrated counseling and contraceptive technology.

- ? Programs to prepare nurses and nurse midwives are limited by two primary factors: there is an insufficient number of nursing and midwifery tutors to support an increase in the size of classes, and insufficient housing for the students. To increase the output of preservice nursing and midwifery programs, recruitment of expatriate tutors should be undertaken, and student housing should be constructed to accommodate more students.

Community-based Services

- ? Since family welfare educators are the major community-based agents for reproductive health, their current job description should be amended to reflect their increased role in family planning and STD/HIV/AIDS outreach, including counseling, referrals, and distribution of condoms, oral contraceptives, and IEC materials.
- ? The curricula for preservice and in-service training of family welfare educators should include reproductive health issues in greater depth and should impart IEC skills needed for everyday work such as client education, counseling, and community organizing. Family welfare educators should be retrained to do family planning and STD/HIV/AIDS outreach as described above. Trainers of family welfare educators should also be oriented to this approach.
- ? Nongovernmental organizations need reproductive health capacity to manage, implement, monitor, and evaluate community-based distribution programs. To facilitate this, the NGO capacity building that was initiated under the BOTSPA Project should be built upon and supported to continue this process.
- ? The private sector should take on increased responsibility for the management and supervision of workplace programs in HIV/AIDS/STD prevention and family planning.

Information, Education, and Communication (IEC)

- ? Managers of reproductive health programs should initiate a strategic planning process that includes interventions with IEC components. They should then devise a workable system for accomplishing key IEC tasks. Such a system should include the involvement of NGOs and other government agencies as well as contracting for outside services as needed.
- ? The MOH should add at least one IEC specialist to the reproductive health team. MOH managers should work with the IEC staff to ensure that careful attention is given to

identifying problem areas, developing strategies to address them, analyzing target audiences, and designing and testing appropriate messages.

- ? The MOH should explore with the Central Medical Stores the possibility of delivering audiovisual and print materials with regular medical supplies. If this distribution mechanism is not possible, the Health Education Unit should set up a regular delivery schedule to the major health service providers.
- ? The training curriculum for family welfare educators should be reviewed to ensure that the content is consistent with their current duties, skills and knowledge. Alternative formats such as local training and supportive supervision should be explored.

Nongovernmental Organizations

- ? The process of strengthening NGO capacity and capability in providing quality reproductive health care and other social welfare services should be continued beyond the life of the BOTSPA Project to sustain and consolidate what has been achieved through BOTSPA. It is important that this be done before current enthusiasm and momentum among NGOs is lost.
- ? NGOs depend on donor funding almost exclusively, and this funding is being withdrawn as donors leave Botswana. It is therefore crucial that the government and the remaining donors consider providing sufficient financial and other resources to NGOs to allow them to develop further their capacities to complement the Government of Botswana's programs in reproductive health and other priority areas.
- ? Given the need and the government's desire to involve NGOs in reproductive health initiatives and the difficulty for the government in dealing with numerous NGOs, the GOB should explore the possibility of encouraging the development or strengthening of a grant-giving umbrella NGO.
- ? A NGO umbrella organization should be supported financially by the government and interested donors and be provided with adequate resources, personnel, office equipment, etc., to enable it to provide capacity building and technical assistance to NGOs and liaise with the government and donors on behalf of NGOs.

Some key areas in which technical assistance may be provided to NGOs include the coordination of NGO plans, reports, and research activities prior to their submission to the government and other donors. Areas of need that are emphasized by the NGOs visited during this evaluation included technical assistance in monitoring and evaluation, operations research, management, organizational development, leadership and NGO governance, NGO networking, development of strategic plans, resource mobilization, and

specific technical areas such as reproductive health, gender, youth programs, and civic education.

- ? To move forward quickly in reproductive health work by the NGOs, the government should consider earmarking a substantial sum (e.g., three to five million Pula) to strengthen NGOs in reproductive health service delivery, including HIV/AIDS/STD Prevention, to complement government efforts in this high-priority area.

Social Marketing

- ? The Botswana Social Marketing Program has made impressive progress in sale and distribution of low-price condoms and dissemination of information and education on HIV prevention. The program should continue to consolidate and sustain successful achievements in condom logistics, increase the use of condoms as an effective measure against HIV transmission, and intensify promotional activities that provide essential information to at-risk populations.
- ? Over the next 3-4 years, the Botswana Social Marketing Program should seek to become more financially self-supporting through a combination of cost-cutting and revenue-producing measures. For the foreseeable future, the government of Botswana will have to continue providing free condoms through the Central Medical Stores.

Management Information Systems (MIS) and Logistics

- ? The MIS need to be strengthened at all levels and become a more important management tool than it is at present, particularly for evaluation, logistics, planning, and strategic decisions.
- ? The training in MIS/logistics that were began under BOTSPA should continue; it should cover more health providers as well as District Health and MOH/MLGLH managers.
- ? The MIS unit at MCH/FP, the Research and Evaluation Section, needs further strengthening in terms of management and technical analysis. Clear objectives should be set by MCH/FP management, and coordination with other information units such as the MOH Medical Statistics Unit as well as with Central Medical Stores should be intensified.
- ? Information developed through the MIS must be disseminated to and used by MOH MCH/FP, the Central Medical Stores and District Health Managers. The CMS must become an integral part of the system.

- ? The Central Medical Stores should remain the main supplier of contraceptives to the public health service, including condoms needed for the social marketing program. Distribution data by district should be passed at least quarterly to MOH MCH/FP.

Sustainability (Financial and Regulatory)

- ? The present public health system, including provision of family planning services, is costly: about Pula 240 (US\$80) per capita per annum. Recurrent health expenditures have increased more than 200 percent over the past four years. Measures should be considered to rationalize out-patient and in-patient prescribing, as well as more use of generic drugs.
- ? Further study into the feasibility of more cost sharing through increased user fees, at least for out-patients and in-patients, should be carried out. The present low initial MCH/FP consultation fee of Pula 2 (US\$0.66), which appears acceptable to most consumers, should be continued for the time being. However, some adjustment should be considered for the future, with allowance made for the very poor.
- ? Availability of oral contraceptives should not be constrained in the private sector by imposing penalties on pharmacists and other outlets who sell orals without prescription, except maybe for the initial consultation and prescription.
- ? The Central Medical Stores should widen its choice of suppliers on the world market, including organizations such as UNFPA and International Planned Parenthood Federation (IPPF), as well as reputable generic manufacturers? supplies should not be constrained because of in-country registration backlogs at the MOH Drugs Unit. However, CMS must demand that supply sources furnish the necessary proof of good manufacturing practices and conform to international quality standards as well as the World Health Organization Certification Scheme before confirming purchases.

Research

- ? Managers of reproductive health programs in all relevant government agencies and NGOs should make greater use of research findings in developing program plans and strategies.
- ? The National Council on Population and Development should collect, evaluate, and disseminate research findings to all interested parties.
- ? A survey of males is needed to determine the prevalence of condom use and use of condoms in conjunction with another contraceptive method. The Central Statistics Office should explore the possibility of adding this component to a house hold survey that is already planned, if it is too late to add it to the Family Health Survey III that is currently under way.

- ? The preliminary findings of the Family Health Survey III should be disseminated as rapidly and extensively as possible.

1. BACKGROUND

Botswana is a large, sparsely populated nation in southern Africa. It is blessed with important natural resources, especially minerals, that have contributed to its economic growth and ranking as a "near middle-income" country. Political stability has also encouraged economic growth over the past 30 years.

Slightly smaller than the state of Texas, Botswana has only about 2 percent arable land, but about 75 percent pasture and meadowlands that can sustain cattle. Rainfall is sparse; 80 percent of the water supply comes from underground aquifers.

1.1 Current Reproductive Health Situation and Objectives

Population. One-half of the country's total population is located within a 100-kilometer (60-mile) semicircle to the north, west, and south of the capital city, Gaborone. Most of the remainder of the population is located along the eastern corridor, bordering South Africa and Zimbabwe. About 50 percent of the population is classified as "urban," defined in Botswana as living in villages exceeding 5,000 persons. Urban growth is rapid? about 10 percent growth per year during 1981-1991. Botswana's population is highly literate compared with many other countries in Africa: the 1991 census found that 49 percent of males and 52 percent of females had attended school. About 70 percent of the residents are Tswana, an ethnic group whose language is known as Setswana; 20 percent are from the Kalanga ethnic group, who speak iKalanga; and 10 percent are from other ethnic groups such as Humbukush, Hereros, Lozi, and Baloi.

Health. Since its independence in 1966, Botswana has made remarkable progress in economic development and in developing its public health infrastructure. A subscriber to the United Nation's goal of "Health for All by the Year 2000," Botswana provides highly subsidized (nearly free), comprehensive medical services throughout the country.

With a total population of only 1.42 million (1996 estimates) the country has over 500 fixed health facilities (hospitals, clinics, health posts). The physical coverage is quite good, with an average of roughly one health facility per 2,500 persons. Moreover, the physical quality of these facilities is impressive: clean, well kept, well equipped, and well stocked. Staff shortages and other factors somewhat limit the overall effectiveness of the fixed facilities, but by and large they seem to provide preventive and curative services that have a real impact on health status.

Indeed, Botswana has made impressive gains in mortality reduction, disease control, and contraceptive prevalence. According to the second Family Health Survey in 1988, the infant mortality rate has fallen dramatically from 71 deaths per 1,000 live births in 1980 to about 45 in

1991. Over 90 percent of pregnant women attend antenatal clinics, 85 percent of births are in a hospital or clinic, and immunization rates for infant and childhood diseases are above 80 percent.

By 1988, Botswana had achieved a contraceptive prevalence rate (CPR) of about 31 percent—that is, 31 percent of women of reproductive age (WRA) were using some method to delay or prevent pregnancies. These are impressive statistics for a developing country in Africa—health planners and practitioners can be justifiably proud of these achievements.

Family Planning and Fertility. Progress since 1988 in contraceptive prevalence is difficult to estimate, although the third Family Health Survey (FHS III) is now under way. This survey will provide current estimates of fertility and CPR. In terms of fertility trends, family size (total fertility rate or TFR) has fallen from 7.1 children per woman in 1981, to 5.0 in 1988, to an estimated 4.8 in 1991. The unofficial Central Statistics Office (CSO) estimate of the present TFR is about 4.2; CSO is using this figure for population projection estimates. Results of the FHS III are being eagerly awaited because the survey is expected to give more insight into the current situation and changes since the 1988 survey. Preliminary findings may be available by the end of this year.

Despite this generally positive and upbeat description, there remain major problems in the current public sector maternal and child health/family planning program and in the country's health situation. The HIV/AIDS pandemic threatens to erode past gains and to limit further progress in achieving a more favorable reproductive health status for Botswana's population.

1.2 Government Programs

The Government of Botswana (GOB) is responsible for over 90 percent of the family health services available in the country. While nongovernmental organizations (NGOs), private clinics, church-affiliated facilities, and private enterprises provide certain health services, they currently serve only a relatively small part of the population.

Health Infrastructure. Reproductive health services are provided by the Ministry of Health (in district hospitals and primary hospitals) and by the Ministry of Local Government, Lands and Housing (in clinics and health posts). Altogether, there are 29 hospitals, 296 clinics, and 411 health posts scattered throughout the country. Over 90 percent of these facilities provide maternal and child health and family planning (MCH/FP) services, although the types of services vary from one facility to another depending on the training and level of health personnel available. In addition to these fixed facilities, there are 834 "mobile stops" where services are offered periodically by itinerant teams of health personnel.

Outreach. In general, very little outreach is now conducted from these fixed and mobile-stop locations, though there were some early attempts at community-based service delivery. Health planners have provided for a cadre of personnel to be used for outreach, the family welfare

educators (FWEs), and have recruited and trained about 700 persons in this category. For the most part, however, the family welfare educators are thus far serving as assistants in health posts and clinics, often because of shortage of staff in the fixed facilities.

Trends in Reproductive Health. Considerable caution must be exercised in describing recent trends, due to the paucity of reliable time-series data on fertility and contraceptive practice, and the unavailability, until very recently, of high-quality program statistics data for analysis. Based on a concerted effort by the evaluation team to ascertain the levels of performance and trends over time, it appears that the following generalizations can be drawn:

1. Condom use appears to have increased considerably as a result of several things, including the Condom Social Marketing Program under the Botswana Population Sector Assistance (BOTSPA) Project, an increasing awareness of the dangers of contracting the HIV/AIDS virus, and a liberal policy of free distribution of condoms by the health services.
2. The most reliable contraceptive methods generally available in the program (intrauterine device, orals, injectables) have shown little progression in the past eight years or so. Specifically, the use of injectables have plateaued, intrauterine devices (IUDs) have decreased slightly, and orals have increased slightly in terms of quantities distributed. In relative terms, taking into account the growth in the number of women of reproductive age, there has been a general decline in these three methods. These observations are based primarily on the distribution of contraceptives from the Ministry of Health (MOH) Central Medical Stores (CMS) between 1988 and mid-1996; they do not directly represent either the quantities of contraceptives actually dispensed by health services or the number of contraceptive users¹. See Figure 1 on page 12.
3. Estimates of maternal mortality range from 200 deaths per 100,000 births (MOH) to 326 (1991 Census) to 462 (UNICEF, based on extrapolations from 1991 Census). However, due to the estimate of one-third of all pregnant women infected with HIV, mortality among females of reproductive age² and their offspring³ can be expected to increase sharply in the near future.
4. The incidence of HIV/AIDS infection has reached monumental proportions in Botswana: a 1995 national-level study found that one-third of pregnant women receiving antenatal services were HIV positive. Of the 3,451 AIDS cases reported during 1986-1995, 73 percent were among young adults aged 20-39; 60 percent of those affected were females, and 40 percent were males. Recent observations in Gaborone have estimated an HIV-infection rate of 60 percent among females, aged 20-29, who attend antenatal clinics, and sexually transmitted diseases infection rate of 85 percent among all antenatal females.
5. Indicators of unmet need for family planning are evident. MOH statistics report that 6

percent of women who died in a hospital in 1992 had had an unsafe abortion; some of the additional 5 percent of deaths due to direct obstetric causes may have been related to unwanted pregnancy.

Objectives. Incorporated in the Seventh National Development Plan (NDP-7) for 1991-97 is a goal of increasing contraceptive prevalence from 30 percent in 1988 to 40 percent by 1997. It is reported that the Eighth and Ninth National Development Plans (NDP-8 and NDP-9) will adopt the goal of increasing CPR to 65 percent by the year 2011. A draft population policy will soon to be circulated for comment, with the aim of achieving national consensus on its principal components by the end of 1996. The draft policy is comprehensive? it covers the roles that all relevant branches of government, NGOs, and the private sector will play to help attain population objectives during the prospective Eighth and Ninth Plan periods.

1.3 Nongovernmental Programs

Due to the relatively good access to government health facilities, private sector organizations and enterprises provide limited health services. Nevertheless, there is an important role for NGOs because government health facilities tend to focus on women who are mothers or about to become mothers. Youth aged 13-19 and men of all ages generally do not visit health facilities for preventive care.

In the reproductive sector, several NGOs are active in public education programs:

- ? The Botswana Family Welfare Association (BOFWA), a member of the International Planned Parenthood Federation (IPPF), has done several youth education initiatives and is planning to offer non-medical methods in a few urban sites.
- ? The Young Women's Christian Association (YWCA) operates an empowerment program for youth. It provides continuing education to adolescent mothers and counseling in schools to prevent unwanted pregnancies.
- ? The AIDS Action Trust (ACT) trains AIDS educators, trainers, and project managers. It has established a resource center and produces training materials for trainers.
- ? Population Services International (PSI)/Botswana sells subsidized condoms through commercial outlets and uses peer education, public presentations, and radio programs to promote condom use.
- ? The Botswana Red Cross Society (BRCS) operates an AIDS information center, mobile HIV testing clinics, and one reproductive health clinic in Gaborone. BRCS also operates home-based care programs for the disabled and plans to expand this program to include

AIDS patients.

Other NGOs include the Botswana Youth Center and the Botswana Women's Council (BWC).

In addition to the work of NGOs in the reproductive health area, the MOH Occupational Health Unit assists employers in developing family planning and HIV/AIDS-prevention programs in the workplace. Coalitions of private sector businesses and trade unions are also involved in workplace programs.

2. EVALUATION PURPOSE AND SPECIFIC OBJECTIVES

The final evaluation of the Botswana Population Sector Assistance Project (BOTSPA) is intended to (a) examine progress to date in implementing the BOTSPA Project as revised in September 1992, and (b) provide insight and guidance for future programs by the Government of Botswana, the United Nations Population Fund (UNFPA) and, possibly, other donors.

Specifically, the evaluation team was directed to do the following:

1. Provide a brief overview of Botswana's reproductive health trends and programs;
2. Review the implementation experience of the three main components of BOTSPA, including: (a) strengthening public sector family planning and STD/AIDS services, (b) condom social marketing, and (c) strengthening the capabilities of NGOs;
3. Assess the sustainability and/or the benefits of activities that are assisted by the United States Agency for International Development (USAID) and UNFPA. Give particular consideration to the utilization of resources to date, levels of support currently provided to the activities, and actions taken to ensure their continuance;
4. Assess the readiness of Botswana's health care systems to deliver integrated reproductive health services, including access (particularly for males and adolescents), quality of care, and public perceptions; and
5. Identify and recommend interventions in the most promising areas for continuing and/or new investment to promote reproductive health, (with particular consideration to) implementation capacity, including human and financial resources, potential impact, and sustainability.

The complete Scope of Work is included in Appendix A.

Upon arrival in country the evaluation team was counseled by USAID/Botswana and the Evaluation Reference Group² to look beyond the confines of the BOTSPA Project itself and consider the overall reproductive health effort in Botswana.

3. METHODS AND PROCEDURES

3.1 Composition of the Evaluation Team

The evaluation was conducted by a six-person team who spent nearly five weeks in Botswana (June 29-July 31, 1996). Team members were selected for their expertise in reproductive health program evaluation; service delivery; community organization and participation; information, education, and communication; management information and logistics systems; and program management.

3.2 Data Collection Methods

The findings and conclusions of this evaluation are based on three main sources: a review of documents, interviews with key informants, and site visits.

Review of Documents. Prior to their arrival in Botswana, team members received some basic documents such as the 1991 Midterm Evaluation, the revised project identification document/Project Paper (PP), and Project Implementation Reports. Information gathered from these materials were greatly expanded on through contacts with USAID, government officials in Botswana, NGOs, and other sources. Appendix B lists the major documents reviewed.

Key Informant Interviews. Team members interviewed more than 110 officials from numerous agencies:

1. Government agencies, including the Ministries of Finance and Development Planning (MFDP), Ministry of Health (MOH), Ministry of Local Government, Lands and Housing (MLGLH), Ministry of Education (MOE), and the National Council on Population and Development (NCPD).
2. Donor agencies, including USAID, UNFPA, and UNICEF.
3. Nongovernmental agencies, including PSI/Botswana, Botswana Family Welfare Association, Botswana National Productivity Centre (BNPC), YWCA, AIDS Action Trust, the Red Cross, the Botswana Boys Center, Botswana Boy Scouts, Mambo Arts, Botswana Council of NGOs (BOCONGO), and the Women's NGO Coalition.
4. Private sector, including Botswana Confederation of Commerce, Industry and Manpower, Botswana Federation of Trade Unions, pharmacies, etc.
5. USAID contractors, including Cambridge Consulting Corporation, Population Services

International, and Population Council.

Appendix C lists the persons contacted by the team for this evaluation.

Site Visits. Team members (individually or in groups) visited various sites around the country that provide reproductive health services and information. These visits covered six districts (Chobe, Gomare, Kgalagadi, Lobatse, Ngamiland, and South East):

- ? 3 district hospitals (Lobatse, Maun, Ramotswa)
- ? 2 primary hospitals (Gumare, Kasane)
- ? 9 clinics (Gumare, Hereford, Kasane, Okavango, Labotse, Maun, Otse, Werda, Woodhall/Lobatse)
- ? 1 health post (Mabele in Kasane)

In addition, several visits were made to the Botswana Social Marketing Program head office in Gaborone, PSI/Botswana, as well as to wholesalers, retail outlets, and peer education sites in Gaborone and three districts. These visits were useful in determining how the BOTSPA Project assisted service providers and outreach programs.

3.3 Evaluation Reference Group

To support this evaluation, USAID formed an Evaluation Reference Group consisting of the Government of Botswana (GOB) officials from the ministries that were involved in the BOTSPA Project. The Evaluation Reference Group made the following inputs: they reviewed the evaluation work plan that the team prepared during the first week of the evaluation; suggested additional documents to review and persons to contact; discussed the team's summary findings and tentative recommendations; and reviewed the draft and final versions of the team's report. The Evaluation Reference Group provided feedback regarding accuracy of facts, feasibility of recommendations, and possible misinterpretations of events.

4. REPRODUCTIVE HEALTH SERVICES DELIVERY

4.1 Introduction

During the past decade, Botswana's overall program performance in reproductive health service delivery has been weak in several key areas. This finding is at variance with the generally accepted view, since Botswana was one of the first sub-Saharan African countries to achieve a significant level of contraceptive awareness and use. Nevertheless, this finding does not surprise program insiders who live with its many problems and who struggle daily to overcome many obstacles to effective service delivery.

While very significant gains have been made in *mortality control* (infant mortality rates have declined to an estimated 45 per 1,000 live births), and antenatal services (some 90 percent of prospective mothers are covered), progress in *fertility control* is far less evident. Data needed to estimate the level of contraceptive services provided by the government program over the past decade are limited; the only data available are the 1988 Family Health Survey II, service estimates for 1994-95, and data on contraceptive shipments from the MOH Central Medical Stores (CMS) for each calendar year. The latter source paints a picture of shipments of the three principal contraceptive methods (orals, IUDs, and injectables) being essentially flat-lined between 1988 and 1996 and declining in relation to the growing reproductive age population (see Figures 1 and 2).

Contraceptive shipments are made following specific requisitions by service outlets, and thus would seem to roughly parallel actual distribution by those outlets (hospitals, clinics, health posts). Data on visits to public health facilities by method for new and repeat users are also available for the period 1985-95. It is uncertain exactly what these figures represent; the evaluation team found evidence that suggested that similar events at the service level are being reported differently or not at all, and the seasonal mobility of the population makes it very difficult to accurately estimate new and continuing users. The overall trend for orals, IUDs, and injectables (Figures 3 and 4) tend to mirror those derived from data on contraceptive shipments from CMS over the period 1988-95. Only condoms have shown a healthy increase (Figure 5), and their impact on fertility control is uncertain at best, though it is hoped they may help to control the transmission of STDs, including HIV/AIDS. Contraceptive choice in 1995 is shown in Figure 6 in terms of new acceptor visits, but it should be kept in mind that dual method use (condoms plus another method, e.g., IUD or pill or injectable) is being promoted due to the high prevalence of STDs, including HIV.

Insert figures 1 and 2

Insert Figures 3 and 4

Insert Figures 5 and 6

Many Positive Elements. There are numerous bright spots, however, including (a) a new population policy draft that articulates problems and sets performance targets; (b) an effective condom social marketing program that reaches a population that is not generally served by government facilities; (c) a promising NORPLANT³ trials effort³; (d) a nascent operations research capability that has already been able to pinpoint serious program deficiencies; (e) a greatly strengthened central training capacity for in-service training of MCH/FP service providers; (f) indications of improvements in reproductive health (RH) services delivery in some locations following BOTSPA-sponsored training; and (g) an apparent commitment on the part of the GOB to continue to provide the resources needed to strengthen service delivery, including contraceptives. Finally, and of major importance, is the ability and willingness of Botswana leaders and managers to recognize problems where they exist, and to openly discuss possible solutions.

4.2 Overview of the BOTSPA Project

The Botswana Population Sector Assistance Project was designed to "improve the quality and availability of family planning and sexually transmitted disease services and to expand AIDS prevention measures."

The BOTSPA Project, which began in July 1988, was redesigned in 1992 to extend project benefits to the district and local levels and to incorporate AIDS-prevention activities. BOTSPA's total budget of US\$5,427,000 was funded by the USAID/Botswana. The Government of Botswana contributed an additional US\$1,822,000 in in-kind contributions, including staff salaries and commodities. Additional funding and technical assistance were provided through the USAID centrally funded Africa Operations Research/Technical Assistance (OR/TA) Project. Although the USAID office in Botswana closed in September 1995, the BOTSPA Project is continuing through September 1996 to allow time for project activities to be completed.

The redesigned project, identified as BOTSPA II in this report, had three major components:

1. Improving the quality of public sector family planning and STD services through an in-service training program for service providers and their managers, print materials production, and strengthening of the management information system;
2. Increasing the demand for and availability of condoms through a condom social marketing program; and
3. Strengthening the capacity of local nongovernmental organizations to design, implement and evaluate reproductive health programs.

The Ministry of Health is the lead government agency in the implementation of the BOTSPA

Project.

Figures 7 and 8 present a tabular and graphic view of important events and milestones in the BOTSPA Project.

Figure 7.

BOTSPA TIMETABLE

| | |
|----------|--|
| MAR 1991 | - BOTSPA I suspended |
| SEP 1991 | - Mid-term Evaluation |
| SEP 1992 | - BOTSPA II Redesign |
| NOV 1992 | - BSMP Startup |
| MAR 1993 | - Baseline KAP re: sexual behavior among youth |
| JUN 1993 | - Lovers Plus condoms launched |
| JUL 1993 | - RFP issued for contractor |
| AUG 1993 | - IFA (Pop.Council) issued for CA re: NGO strengthening |
| SEP 1993 | - 15 TRGs appointed; CTS -STD clinical training |
| OCT 1993 | - Change in AIDS peer education plan noted in PIR |
| DEC 1993 | - PSI Consumer Intercept Study |
| APR 1994 | - CCC resident advisor arrives; CTS-CTU course completed |
| MAR 1994 | - Male KAP survey done 1990-91 published |
| AUG 1994 | - Training consultant 1st trip |
| SEP 1994 | - Leadership conferences; CDC completes FP/STD report |
| | - Notification that funding will continue until Sept 1996 |
| | - PSI youth advisory proposal amended to exclude in-school youth |
| DEC 1994 | - IEC consultant trip #1 conclusion IEC materials are sufficient, train FWEs instead |
| | - PSI consumer intercept study |
| JAN 1995 | - Prototype Training Information System designed |
| | - Decision to forego training supervisors, shift to ?centers of competence? |
| | strategy |
| FEB 1995 | - IEC consultant trip #2; 6 IEC promoters trained |
| MAR 1995 | - TRGs trained (17) |
| | - Lack of ASU involvement jeopardizes integration |
| JUL 1995 | - Negotiations in progress for NGO activity (Population Council) |
| AUG 1995 | - Activity Management Committee re-established |
| SEP 1995 | - Population Council begins Situation Analysis & NGO work |
| | - Nurse-midwives and FWEs trained (102) |
| | - PSI Botswana formed |
| OCT 1995 | - IEC consultant trip #3; 9 IEC promoters trained |
| DEC 1995 | - Mid-term internal evaluation of training activities; 3rd staff member added to CTS |
| JAN 1996 | - Second group of TRGs trained (15) |
| MAR 1996 | - End of USAID funding for PSI/BSMP |
| | - Nurse-midwives and FWEs trained (203) |
| APR 1996 | - 1994 MCH/FP Annual Report released |

- MAY 1996 - Approval of revised FP policy guidelines
- MAY 1996 - Head of CTS promoted; new CTS head appointed
- JUN 1996 - Situation Analysis draft published
- JUN 1996 - Rapid Quality Assessment Tool completed
- JUL 1996 - Family Health Survey III in field
- JUL 1996 - BOTSPA Final Evaluation Team in field

Figure 8.

BOTSPA PROJECT MILESTONES

| Element | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 |
|--------------------------|---|-------------------------|---|--|---|---------------------------------------|--|--|--|
| TRAINING | | | | | | CTS & TRG established | | March: 17 TRG trained May: TRG svc providers Sept: 102 service providers trained | |
| CCC \$1,348,316 | | | | | | July: RFP issued | April: Resident Advisor arrives | | Sep: project ends |
| PSI/CSM \$1,242,000 | | | | | Nov: PSI project start | Mar: baseline KAP Jun: LP launched | Jan: consumer intercept study | Aug: PSI /Botswana formed | Feb: followup KAP Mar: end of USAID funding |
| POP COUNCIL \$481,745 | | | | | | Aug: IFA issued | | Sep: project begins (Sit Anal & NGO) | Sep: project ends |
| RESEARCH | Aug-Dec FHS in field; KAP males 20-29; teen pregnancy study | August FHS published | May 90-Mar 91 KAP males 13-69 in field | National Census | | | Male KAP published | Situation Analysis in field mid-year | July: Situation Analysis draft published July: FHS-III in field |
| IEC | IEC workshop; design 3-yr IEC program | | | | May: Ruth Berger made IEC plan, revised materials | | Dec: Alan Kulakow reviewed materials, made IEC training plan | Feb-Mar: 6 IEC promoters trained; Oct: 9 IEC promoters trained; Oct-Dec: Kulakow 2 IEC workshops | |
| BOTSPA | July 1988 | | Dec: USAID hires project manager | Mar: project suspended Apr: USAID/-GOB revision Sep: Mid-term evaluation | Sep: project | | | | July 1996: Final Evaluation |

| Element | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 |
|-------------|---------------|------|------|------|----------|------|------|------|---------------------|
| \$5,427,000 | Project start | | | | redesign | | | | Sep: End of Project |

4.3 Family Planning, STDs and AIDS Services

4.3.1 Health Infrastructure

Two ministries are responsible for health services:

? The Ministry of Health is responsible for establishing health policy and overall implementation plans, determining manpower requirements, training, administration and staffing of hospitals and their clinics, and providing technical direction for all health initiatives.

? The Ministry of Local Government, Lands and Housing (MLGLH) is responsible for implementing health programs at the district level.

Within the MOH, the MCH/FP Unit of the Family Health Division, in the Department of Primary Health Care Services, is responsible for overseeing family planning services. The AIDS/STD Unit, which is also part of the Department of Primary Health Care Services, is responsible for overseeing AIDS and STD services. The Health Unit in the MLGLH (consisting of one physician and one nurse) constitutes the link between the two ministries and has the formidable task of assisting one to implement the plans and programs of the other.

The training and management information system (MIS) components of the BOTSPA Project are based in the MCH/FP Unit. The Central Training Section (CTS) of the MCH/FP Unit is composed of two nurse midwives (one of whom is designated as Section Head) and the project's long-term resident advisor, who is a physician. This advisor is employed by Cambridge Consulting Corporation (CCC), which provides technical assistance to the BOTSPA Project under a subcontract with USAID/Botswana. The Cambridge Consulting Corporation has also provided short-term technical assistance using U.S.-based consultants. The Central Training Section has been largely responsible for developing and implementing the BOTSPA training program for service providers and community educators and overseeing the inclusion of IEC, MIS, and logistics training in the training curriculum.

4.3.2 Management and Planning

4.3.2.1 Overview

The overall purpose of the BOTSPA Project is to improve the quality and availability of family planning and STD services. By implication, it is the work of those designing, implementing, and monitoring project activities to ensure that interventions build momentum toward the eventual institutionalization and sustainability of high-quality family planning and STD services. Management and planning are important components of this work.

The evaluation team found that there were deficiencies in both the management and planning[?] and the redesign[?] of the MOH portion of the BOTSPA Project. The responsibility for these deficiencies is shared by all the partners involved in implementing the BOTSPA Project[?] USAID, the MOH, and the Cambridge Consulting Corporation. It is relatively easy to see and identify the nature of these deficiencies in retrospect; no doubt it was not so easy to do this at project outset.

Project Design. Perhaps the most fundamental flaw was the initial BOTSPA Project design, which included both a nonproject assistance (NPA) component and a projectized component. Within three years it was apparent that NPA was not working; the project was suspended in 1991. Following an external evaluation, the project was redesigned and approved in the fall of 1992. The NPA component was eliminated and resources were transferred to the projectized component.

In the redesign, the MOH was to implement the project. The Ministry of Local Government, Lands and Housing, which is responsible for the delivery of health services in clinics and health posts, was not fully involved as a project implementation partner. In retrospect, given the expectation for institutionalization of family planning and STD services through the District Health Teams in the MLGLH, this arrangement now seems unrealistic.

Project Management. Another management problem stemmed from the absence of a counterpart project manager; that is, a senior person responsible for implementing BOTSPA activities within the MOH. This was a structural defect in the project design. Responsibility for these activities was divided between two functional units of the MOH Family Health Division: the MCH/FP Unit and the Health Education Unit. Thus project activities tended to be pursued as isolated efforts rather than coordinated, interrelated efforts.

By default, decisions on project direction fell on the Central Training Section, the only section in the MCH/FP Unit working specifically on family planning. CTS staff have demonstrated dedication to their work in training and other related areas assigned to them. However, the expertise of the CTS staff is in design and management of training. Therefore, their programmatic decisions reflect a training bias rather than a more holistic program orientation in which such concerns as overall project direction, staffing and supervision, supplies and logistics, MIS, IEC, funding and other resource allocations are addressed.

Overall project coordination and management was conducted through two committees:

1. The Activity Management Committee (AMC), whose membership included the MOH/Family Health Division Chief Family Health officer; MLGLH Principal Primary Health Care Officer; USAID Health, Population, and Nutrition (HPN) Officer; and the Cambridge Consulting Corporation Resident Advisor;

2. The Project Reference Group (PRG), which had the same membership as the Activity Management Committee plus two staff from the Ministry of Finance and Development Planning and one from the AIDS Support Unit (ASU). The Activity Management Committee was scheduled to meet quarterly, and the Project Reference Group, semi-annually. The meeting schedule of the PRG was maintained. The purpose of the committees was to advise and approve changes in project activities as suggested by individual program implementers. These meetings took the place of any formal project amendment process. According to a USAID audit on sustainability conducted in August 1995, through the success of the meetings? The Mission and the Government have consistently concurred on progress, problem identification, action plans, and status of host country contributions.?

No doubt these committees played an important role in keeping some activities on track. But in the absence of a single counterpart responsible for day-to-day project oversight and implementation, much of the original intent seems to have been lost. Without this type of leadership, the project remained a set of minimally integrated training activities, never developing into a service delivery-focused program as intended in the project design. Indeed, the project design appears to have been modified somewhere along the line, reducing the project purpose to one of ?institutionalization of in-service training for health workers providing family planning and STD services? (Mid-Term Progress Meeting and Training Evaluation Report, December 1995).

On the USAID side, delays were incurred in the contracting process which resulted in the late arrival of the contractor, Cambridge Consulting Corporation. This meant that activities that had originally been planned to take place over a four-year period were now compressed into less than two years. In addition, USAID?s decision to close out its activities in Botswana and terminate all BOTSPA Project spending by September 1996 may have jeopardized the continuation of important activities began under BOTSPA, which, in other circumstances, would likely have been supported through a USAID follow-on activity. Given the stress of the shortened implementation period and the requirements of three intensive training initiatives, it is understandable that the project focus shifted to training.

4.3.2.2 Planned Management Activities - Design and Implementation

As shown in recent studies, inadequate supervision is a serious weakness in the district health service delivery system. To address this problem, the BOTSPA II Project planned to train district-level supervisors to: 1) appraise the performance of individual staff in providing FP/STD services such as education/counseling, and collecting, using, and reporting FP-related data; and 2) help staff to solve problems observed during these appraisals.

The plan for BOTSPA training was for the MOH to conduct a supervisory training needs assessment for community health nurses (CHN), recommend changes in the supervisory system, and train 49 district-level supervisors in service provision, use of MIS data, problem-solving, and data reporting.

Later the MOH staff learned that the community health nurses were not available for training and the "centers of competence" strategy was created to fill the supervision gap. The plan was to train teams (one supervisory midwife, one junior midwife, and two family welfare educators) operating from one service center, rather than one service provider per site as originally planned.

The senior nurse/midwife was to provide supervision at the local level and the team would provide positive peer support to facilitate an environment conducive to the continued application of improved skills. This strategy was implemented with the support of USAID and the Project Reference Group. District Health Teams (DHTs) were notified and were involved only in identifying staff to be trained.

Under the new strategy, the only district-level staff trained were those who happened to be trained as training resource groups or who received on-the-job training from trained service providers. No organized effort was made to train District Health Teams/District Ministry Of Health (DMOH) staff in the key area of the collection, use and reporting of FP-related data.

While there is anecdotal evidence that some centers of competence have functioned as intended, their effect on service delivery is not yet known. What is known is that the incubator effect of centers was easily undermined by transfers of key staff. Unpredictable transfers that are out of the hands of local authorities and program planners have to be a central factor in planning program strategies.

Strengthening the supervision support system through the community health nurses was the key project link between training and family planning and STD program management by the district level. The center of competence approach was an important short-term measure but not a substitute for the upgrading of supervision skill. It left the implementation of the program to chance by leaving the District Health Teams and the District Ministry Of Health, the bodies responsible for district/hospital planning, budgeting, and implementation, out of the supervision, implementation, and monitoring cycle.

4.3.2.3 Additional Management and Planning Constraints

Project Implementation in Districts by District Health Teams. The primary ministry-to-ministry coordination link for the BOTSPA Project was between the MOH MCH/FP Unit and the MLGLH Primary Health Care Unit. There is no active mechanism for mutual planning and coordination between the MCH/FP Unit and the DHTs. Without a specific project strategy agreed to by the MOH and the MLGLH for the operational implementation of FP/STD activities, the coordination between the two ministries focused on agreement of project activities and negotiating training logistics. Indeed, with the change in the approach to supervisory training, the opportunity for collaboration on the operational level was lost. By the close of the BOTSPA Project, the District Health Teams were no further along in terms of their ability to plan and support FP/STD activities than they were at the beginning of the project.

Models of initiatives that have been successfully coordinated and implemented through the MOH and MLGLH are those that have been managed and carried out by the district teams at the district level with technical support from Family Health Division program managers. Senior officials reported that successful initiatives have been vertical programs (e.g., the Expanded Program on Immunization, acute respiratory infection, malaria) and have included district-level training, technical support, and a MOH program manager who worked closely with district managers. Senior officials also state that funds for districts to carry out the program were also important. One MOH official stated that successful collaboration and coordination resulted from "program managers rubbing shoulders" with their district-level partners.

Intra-ministerial Planning and Coordination. There is no joint planning or overall coordination of reproductive health/family planning/STD activities carried out by MOH units. There are a series of activities, but no integrated program. Lack of coordination has led to the duplication of efforts and costs in human and financial resources in project areas, including the development of counseling curricula, infection prevention procedures, and training.

The urgent need to address the AIDS crisis requires that the level of authority for reproductive health/family planning in both the MOH and MLGLH be raised within the organizational structure. The RH/FP group should immediately develop and coordinate strategic plans with key players to assure a targeted, integrated program.

Human Resources. The shortage of trained health personnel affects the management and implementation of all health programs in Botswana. The BOTSPA Project was no exception. Family Health Division units involved in FP/STD programs regularly had two to five staff vacancies. Staff members are stretched thin, while programs (e.g., safe motherhood, HIV/AIDS, reproductive health) continue to grow in number and complexity. Clinic staff are under time pressure to deliver services so integrated FP/STD counseling is not carried out. The manpower plan forecasts the alleviation of shortfalls in nurses and nurse/midwives by the year 2011. Until that time, the strategic training and use of human resources will be required, including supporting the development of NGOs and the private-sector to carry out tasks currently assigned to health staff, such as community outreach and provision of condoms and oral contraceptives. Outsourcing for specific products should be considered (see IEC section 4.3.5).

Recommendations

1. Together with the Ministry of Finance and Development Planning, the Ministry of Local Government, Lands and Housing and MOH need to develop a clear vision and strategic plans for complementary, district-centered family planning/STD programs to operationalize population policy strategies.
2. Since services are delivered at the local level, district health managers (District Health Teams and MOH) need to be the focus for developing and implementing operational plans for the FP/STD program.
3. The level of authority for reproductive health/family planning in the MOH needs to be raised in the organizational structure to give sufficient attention to priority reproductive health/family planning/STD/AIDS needs. Similarly, the Ministry of Local Government, Lands and Housing needs to give appropriate importance to reproductive health in its management structure. Both ministries need to appoint full-time managers for the priority reproductive health program.
4. A supportive supervision process carried out by the District Health Teams and MOH supervisors at each site should be adopted. The ?Triple-A Supervision Initiative? that is being carried out by the Ministry of Local Government, Lands and Housing and MOH offers a model of site self-directed assessment, analysis, and action that should be considered.
5. The future role, responsibilities, and objectives of the Central Training Section need to be clarified. It is the judgment of the evaluation team that overall responsibility for the reproductive health program in the MOH would not be an appropriate role for the Central Training Section, rather it should continue to be responsible for the family planning and STD training.

6. Program strategies need to take into account the disruptive effects of the continuous changes in staffing due to transfer, local training, and long-term external training.
7. Programs that require timely scheduling, decision-making, and problem solving need communication systems? telephone lines and faxes? and budgets to support them so that precious human resources are not squandered due to lack of simple solutions.

4.3.3 Training for Reproductive Health

4.3.3.1 Preservice Training

Currently there are training programs for general nurses and nurse-midwives at the Institutes for Health Sciences, which are part of the MOH; a BEd program for educators and administrators at the University of Botswana; and an upgrade program for enrolled nurses to bring them up to the level of general nurses. The Council for Nursing is responsible for registration of nurses and is operating under old legislation that is very outdated and will be replaced within the year. The new legislation regulating nursing practice has been approved and is awaiting implementation. It calls for the registration of all nurses and requires that a standard examination be passed by all nurses working in Botswana; this includes expatriate nurses who are being actively recruited to ameliorate the shortage of nurses in the health care system.

Basic and midwifery nursing courses have recently been revised based on work with the Kellogg Foundation that identified the need for new curricula. These curricula were initiated in 1994, and the first classes are just getting ready to graduate.

The midwifery program, an 18-month post-basic course, integrates family planning and HIV/STD prevention and treatment throughout the curriculum rather than treating it as a separate subject. Midwives learn to consider contraception and illness prevention and treatment in the context of pre-partum, inter-partum, and post-partum interventions. Family planning counseling and IUD insertion are part of their experience in the clinical areas, and the graduates of this revised program are meant to have a stronger background in family planning/STD/HIV than their predecessors. Some of the faculty believe that new graduates can be expected to practice at a beginning level, and should have continuing education opportunities and supervision to strengthen their skills in the practice sites.

The general nursing curriculum provides introductory coursework on contraceptive methods and family planning management, and new graduates are not expected to function independently in this area of practice. In-depth orientation and on-the-job training are necessary to bring them to an acceptable level of practice.

The enrolled nurse upgrade program builds on the clinical experience that enrolled nurses have had in their practice before they entered the upgrade program; academic courses are more theoretical, and there is no special attention to FP/STD/HIV. Their knowledge of and ability to provide services are likely based on on-the-job training that they received.

There is a critical shortage of nurses and nurse midwives in Botswana. The classes at the Institutes for Health Sciences are small, reportedly due to limited housing for students and the small number of qualified nursing tutors. There is a good deal of advanced training of nurses in specialty and higher degree programs at home and abroad, which is very positive; however, it increases the amount of time required to enlarge the pool of well-trained providers.

Conclusions

There are differences of opinion among the faculty and between the faculty and the Central Training Section about whether new nurse midwives can walk into a practice site upon graduation and provide reasonably good counseling and interventions in family planning and STD prevention and treatment. It is clear that no other category of provider in Botswana can do so. To improve and maintain the quality of care, all service providers require in-service education, supervision, and support that are not currently available in the system except through the limited capacity of the BOTSPA training.

There are insufficient numbers of nurses and midwives to staff the hospital and district clinics throughout the country, as indicated by the number of vacancies in funded positions. Until the shortage is remedied, there are not enough providers able to meet the reproductive health and other health needs of the population.

Recommendations

8. It is incumbent on the nursing profession, which is the mainstay of the health care system in Botswana, to create strong, clinically focused, preservice family planning and STD curricula in the midwifery and general nursing programs, and an emphasis on family planning and STDs in the enrolled nurse upgrade program. Midwives and nurses should be able to walk into their first jobs after graduation and practice fully, confidently, and competently in these areas.
9. All Institutes for Health Sciences faculty should attend the BOTSPA training in order to fully appreciate the impact of competency-based training and become committed to strengthening the clinical focus in the preservice programs.
10. The number of midwives and nurses being trained should be increased by a) recruiting nursing tutors from other countries until there are sufficient Botswana tutors to handle

larger classes; and b) construct additional student housing to accommodate larger numbers of students.

11. Intensify the recruitment of well-trained nurses from other countries to fill vacancies in the nursing structure and provide a thorough clinical orientation to FP/HIV/STDs in Botswana so that they are able to provide high-quality services.

4.3.3.2 In-Service Training

As far as the evaluation team could ascertain, in-service training for service delivery staff in the districts seems limited to clinical conferences that are arranged by education-oriented matrons. Individuals are sent for training, which may be long or short term, and the benefits of their training may or may not accrue to the service delivery site in a tangible way for the other staff. The exception to this situation is the training that accompanies a major campaign such as those for acute respiratory infections and malaria, which initiated from the MOH and were implemented by the districts (MLGLH). The BOTSPA training program is intended to be the in-service training that upgrades the quality of reproductive health care.

BOTSPA Training Program

Central Training Section. The Central Training Section of the Family Health Division, which is the implementing and training arm of the BOTSPA Project, is staffed by two nurse midwives with the support of a physician long-term advisor. Because neither of the current staff was an experienced trainer when she joined the project, both have had to learn their training skills while learning to develop and implement a program that would, in most countries, be conducted by Master Trainers or with long-term Master Trainer technical assistance. The development and implementation of a complex training program also requires program management skills, and supervisory skills are needed to follow up on the efficacy of the training once it has been delivered. Neither of the two current staff had this experience prior to joining the Central Training Section. The original Head of the Section, who came to BOTSPA with some of these skills, was promoted out of the section in May 1996, once again reducing the staff to two. The newest member of the staff was appointed Head of the Central Training Section only five months after she joined the staff.

The Central Training Section is responsible for curriculum development, training program planning, management, and implementation, easily full-time jobs for more than two people. Unfortunately, the shortage of people who can carry out other activities in the MCH/FP Unit has required that the CTS staff take on tasks that are not related to BOTSPA, often at crucial times in the BOTSPA schedule.

The Training Resource Group. Members of the Training Resource Group were selected by the Senior Matrons in their hospitals or clinics.

A six-week training of trainers course was developed by the Central Training Section with technical assistance from their short-term training consultant. The course provided approximately the following hours of training:

| | | |
|---|-----------------------------------|------------|
| ? | contraceptive technology update | 27 hours |
| ? | counseling | 31 hours |
| ? | classroom work on clinical update | 25 hours |
| ? | administration of training | 13 hours |
| ? | classroom practice of skills | 27 hours |
| ? | management information system | 12.5 hours |
| ? | IEC | 1.25 hours |
| ? | infection prevention | 2.5 hours |
| ? | supervision | 1.25 hours |
| ? | clinic practice of skills | 25 hours |
| ? | group study sessions | 23 hours |
| ? | training skills | 5 hours |

The emphasis of this curriculum is clearly on skill-building for clinicians in contraceptive technology updates, training in counseling, STD prevention and treatment, and HIV/AIDS prevention. The time spent in clinic practice of skills was dedicated to counseling, gynecological exams, and IUD insertions.

The midwives who completed this course were asked to go back to their clinics and implement the clinical skills they had learned; report what they learned to the senior district medical officer and senior matron with the hope that they would be able to introduce changes in their settings consistent with what they had learned in the training program; train other midwives and nurses who work in the MCH/FP areas in their facilities; and take on the responsibility of planning for, organizing, and delivering training programs to other midwives on a regularly scheduled basis. Moreover, midwives who completed the course were asked to supervise the practice of those they have trained, an ever growing group of midwives who work in other clinics. In addition to these expectations, participant midwives are still required to rotate through other services and shifts like the other nurses who work in their facilities.

Service Delivery Nurse Midwives. When it was discovered that the community health nurses would not be available to participate in the training or serve as supervisors to support the institutionalization of the integrated family planning and STD/HIV/AIDS training, it was decided that training individuals in isolated facilities would not serve the purpose of the BOTSPA Project. A decision was made to create ?centers of competence? in which more than one provider was trained with the hope that pairs or trios might support each other?s work and teach

others what they had learned. Only nurse-midwives were to be trained in this scheme.

Again, Senior Matrons were asked to nominate nurse midwives to participate in the training. In December 1995, the Central Training Section articulated several administrative criteria for selecting participants: someone who is interested in family planning, not near to retirement, or an expatriate who is not near the end of her contract; and someone not likely to be transferred soon.

Matrons are being asked to consider these criteria as they nominate future participants in the training course. However, the nurse midwives who receive training are also subject to transfer out of the facility and rotation through other services and to night shifts, where they are not as likely to use their newly acquired skills.

The training courses in which they participate provide roughly the same number of hours of training as the training of trainers course (additional time in the TOT was used to give the larger number of participants time in the clinical area; other participants used it to design sessions).

BOTSPA Training Provided by CTS. The BOTSPA Project has developed excellent curricula and provided very good training to the following:

- ? 3 Central Training Staff
- ? 31 Training Resource Groups
- ? 73 nurse midwives
- ? 15 IEC promoters
- ? 155 family welfare educators

Training programs have been developed for a TOT course for the Training Resource Group; this is adapted to become the training for midwives, an IEC course for midwives who are designated IEC promoters, and an IEC course for family welfare educators.

Because the Training Resource Groups were intended to be experienced trainers who would require a contraceptive update and team-building, their preparation for the role was to have been a series of on-the-job training exercises. As noted above, this plan did not materialize, and the Training Resource Groups who were nominated by senior matrons in various hospitals and districts were not trainers, thus they needed to go through a TOT course. The course that was developed focused on the contraceptive update, and the manual that was developed has little content related to training skills. There were opportunities to develop and teach sessions in the course, and feedback was given to trainees on the preparation and delivery of their sessions. This methodology requires that there be additional supervisory inputs, and at least another year of support for the Training Resource Groups from a short-term training consultant. The current visit from the short-term training consultant will focus on the development of follow-up training check-lists and guidelines, which constitutes the Training Resource Groups' clinical supervision of the trainees. This follow-up is an essential part of the training cycle, and updating of curricula

is based on the findings from these visits.

The Trainers Guide that was developed for both the TOT and nurse midwives' training has one notable gap in addition to the absence of training skills materials. It does not provide for a reflective cycle at the end of each unit that would help participants to review the material, explore its meaning, and think about how they will use it in their practice. It is this step that often solidifies the learning and closes the loop that leads to effective implementation. Making it explicit in the manual will help trainers to remember to include the reflection cycle in their training sessions.

The work with the Training Resource Group was meant to produce revised family planning standards and guidelines. Policy guidelines have been revised and approved, but not yet promulgated. These guidelines include the elimination of medical barriers (age and parity restrictions) as recommended in September 1994 at the Leadership Conferences and subsequently approved by the MOH. As yet, many providers in the field are unaware of these policy changes; promulgation of the Policy guidelines should proceed immediately. The Family Planning Procedure Manual is still undergoing revision, and such important issues as new infection prevention guidelines have not been implemented yet in some facilities.

The four-week training for midwives covers all content areas thoroughly, and provides them with supervised practice in counseling and method provision. HIV and STD prevention and treatment are integrated into the curriculum (the one clinical encounter that the team was able to observe was extremely thorough, and the STD-prevention message was included). A decision to keep the class size to six was based on the difficulty in recruiting clients for IUD insertions; the high trainer-participant ratio makes this training very expensive in terms of time (removal from service of both trainer and participant) and cost. Many of the midwives have not been able to do the required number of IUD insertions to assure their competence in delivering this method.

Project Activities and Resource Contributions. In February-March 1992, the Program for International Training in Health (INTRAH) was commissioned to develop Recommended Strategy Options for In-Service FP/STD Training for the Redesigned BOTSPA Project. A thorough study of the clinical service, management and supervisory systems in both the MOH and Ministry of Local Government, Lands and Housing led them to develop three strategy options which were reviewed by a reference group, USAID, and representatives from other agencies. Out of many discussions, INTRAH amended and reconfigured its recommendations to reach a consensus, and a broad and in-depth approach to training was presented, with full supportive documentation of timeliness, cost estimates, training configurations and clinical manuals on which to base the training.

The 1992 redesign was clearly based on the INTRAH recommendation; however, conditions in Botswana had changed by the time the Cambridge Consulting Corporation resident advisor

arrived in April 1994, and over time the carefully constructed interlocking pieces of the INTRAH design were disaggregated, creating a training program that does not have the administrative supervisory structures in the MLGLH that are necessary to make it sustainable. The late start and unexpected withdrawal of USAID has left too little time for the project to take hold (21 months) and fewer resources than were planned to make it work.

The 1992 re-design called for the following:

USAID Inputs

A long-term technical advisor, preferably a nurse midwife or family planning nurse practitioner with substantial training experience to (a) work with short-term technical advisors to train the Central Training Section and evaluate curricula, train the Training Resource Group, and design and install an in-service training database; and (b) serve as chief of party to coordinate USAID assistance and the work of all short-term technical assistance assigned to the activities. In fact, the advisor is a physician who has served a primarily administrative role. Project activities include the following:

1. Conduct BOTSPA orientation seminars for district-level primary health care managers to inform them about the training and solicit their input for its design and implementation.

Leadership Seminars were held in September 1994 in Gaborone and Francistown to orient district and national leaders to the BOTSPA training program. These seminars were held in conjunction with a meeting about the Safe Motherhood initiative, and some participants indicated that they did not realize there were two different projects being discussed. The original intent was to hold meetings that would engage the district-level leadership in the training programs and solicit their input about design and implementation of the BOTSPA Project in the districts; however, the report of the meeting indicates that the roles that were represented were very different from those that were suggested, and that most of the time was spent on contraceptive update and important discussions about reducing medical barriers.

2. Conduct a training for trainers course for Central Training Section and Training Resources Group members (who were intended to be fully formed trainers selected from an INTRAH-developed roster of trainers with third-country TOT).

While the short-term consultant spent a great deal of time working with the Central Training Section on curriculum design and discussions about participatory and competency based training, no formal TOT course was held for the Central Training Section staff. The TOT provided for the Training Resource Groups was initially allocated two-three weeks; it was expanded to six weeks, which gave more time for

developing clinical and training competence; but it should ideally have been an eight-week program with additional time devoted to training skills development.

3. Assist the Central Training Section to design competency-based FP/STD curricula for all levels of service delivery staff based on needs assessment and surveys of service quality conducted under USAID's program monitoring system.

Curricula were designed for several training programs with the guidance of the short-term training consultants in family planning/counseling, IEC, and MIS. There is a TOT for the Training Resource Groups, which is also the curriculum used for the service delivery staff; a TOT for the IEC Promoters; and a Family Welfare Educator course. The plan to train general nurses was dropped, so a curriculum was not developed. Surveys of service quality were not available at the time that the curricula were being developed; a Situation Analysis was conducted under the leadership of the Population Council in June 1995 to serve that purpose, and that technology has been adapted (June 1996) for use as a Rapid Assessment Tool by Training Resource Group members. They will begin to visit clinics within the next two months.

4. Assist the Central Training Section and Training Resource Group to train approximately 480 providers targeting all supervisors of FP/STD service providers: one or two midwives from every hospital, one midwife from every clinic, one nurse from every health post without a midwife and one Family Welfare Educator from every health post without a midwife or nurse.

As noted above, this plan was changed due to the unavailability of community health nurses to provide the crucial supervisory support. The number of persons to be trained was reduced to 228 nurse midwives and 77 family welfare educators. To date, 73 nurse midwives and 155 family welfare educators have been trained.

5. Identify and equip two to four training sites with accommodation for trainees and nearby clinics with sufficient client volume in which they can practice skills. Initially, four sites were selected and equipped; subsequent logistical problems made it more feasible to use only two of the sites.
6. Evaluate the training using USAID's program monitoring system and observation and review of documentation.

The Situation Analysis, modified for use in Botswana and adapted for use as a Rapid Assessment Tool, will form the basis of training evaluation. That process is scheduled to begin shortly.

7. Revise curricula based on evaluations. As the evaluation process has not yet begun, the

curriculum revisions that have been made have been based on experience in the training programs.

8. Design and install a computerized in-service training database. The database has been designed and installed; however, the data is not complete, so the system is not yet useful.

Government of Botswana Inputs

1. Establish the Central Training Section on a full-time basis.

The Central Training Section has been put in place, but the staff are often required to carry out other activities, which reduces their time that is available to BOTSPA to less than full-time. The need was identified early on to increase the number of staff from two to three, and after a long delay a third person was added; six months later, the head of the section was promoted and not replaced, once again reducing the number of staff to two.

2. Appoint the 16-member Training Resource Group.

It was intended that the Training Resource Group would be selected from a roster of previously trained trainers who could be updated and brought into a cohesive BOTSPA group. As noted above, this did not occur, and 31 new TRGs were trained to carry out the training. Some fewer than that are active.

3. Assign a full-time Primary Health Care Officer to the Ministry of Local Government, Lands and Housing to facilitate coordination with the MOH in the design and provision of the training.

There is a full time Primary Health Care Officer in place at the Ministry of Local Government, Lands and Housing. It is not clear how much of his time is related to BOTSPA, but he travels in-country for sufficient periods of time so that the requests for release of participants for training, which are required to go through his office, are often bottlenecked there for long periods of time, compromising the organization of the training programs. He informed the evaluation team that additional staff will be assigned to his office, which currently consists of himself and a nurse.

4. Provide one nurse with substantial counseling experience and at least three part-time content specialists (family planning, STDs, AIDS) to assist with training needs assessments and curriculum design.

There is no evidence that the Central Training Section had any help with needs assessments or curriculum design from anyone other than the Cambridge Consulting

Corporation short-term consultants.

5. Local training costs. Local training costs have been paid by the government.
6. Office space, utilities, administrative and secretarial assistance, and basic stationery for the long-term advisor, Central Training Section and short-term consultants.

These have been supplied in insufficient quantity according to all staff. The constraints on the use of, and the ineffectiveness of the telephone have seriously compromised the Central Training Section's ability to communicate effectively with the districts, and it has hindered its ability to contact Training Resource Groups about training assignments and District Health Teams to ensure the release of trainees for courses.

7. Ensure that health facilities are adequately equipped. This is a work in progress, and will be monitored by the Rapid Assessment Tool.

Conclusions

The Central Training Section and Training Resource Group staff have learned a great deal in a short time. They would benefit from an opportunity to consolidate their learning in a TOT that encourages them to learn training skills through an experiential learning cycle in order to provide strong, dynamic training for service providers. Considering the difficulty that women face in advocating for themselves and their safety, the trainers need an opportunity to practice self-protection (i.e. negotiation about use of condoms) in order to help service providers learn how to coach their clients in demanding condom use.

The Central Training Section and Training Resource Group would strongly benefit from a long exposure to a master trainer nurse midwife to help them focus on the importance of client choice for effective use of contraception. In order to help clients make those choices and feel free to come back and report their level of satisfaction with a method, it is essential that counseling staff have the best possible communication skills. These skills are not emphasized and may not be highly valued in basic training programs, and therefore need to be introduced and taught carefully and thoroughly in the in-service training. It is essential that those responsible for FP/STD/HIV counseling internalize the values inherent in good counseling that include coaching on self-protection through assertiveness. A six-month continuous technical assistance contract would provide this.

The BOTSPA Project has provided an important opportunity for a small training component to develop its capacity to deliver widespread competency-based in-service training. The CTS has learned and applied curriculum development skills; and the project has helped to build a base of trainers who specialize in FP/STD/AIDS.

The apparent leveling off of contraceptive prevalence and the frightening STD/HIV statistics create a compelling case for training more service providers more quickly to improve their knowledge of contraceptive technology and STD/HIV, and their ability to counsel clients in these areas and provide adequate services.

Because the project is really only at the halfway point of its four-year life, it is too soon to make any definitive judgments about its effectiveness. We know that in a small study of service delivery, there was an increase in services provided in clinics with BOTSPA-trained staff. Changes included a desirable shift in method mix toward longer-term methods. The Rapid Assessment Tool that will be fielded in the next two months will also provide a measure of training impact addressing quality of care more directly. Periodic use of this tool will provide important information on the effectiveness of the training.

Until sufficient time has elapsed to study the effectiveness of the competency-based training, it is important to continue to support it, and to develop the follow-up for trainers, training of leadership personnel, and on-going monitoring and evaluation of the training program itself.

The extremely high prevalence of STDs (measured at 85% of women in a pre-natal clinic in Gaborone by the Support for Analysis and Research in Africa Project in 1995) raises a question about the risk of expanding IUD use in Botswana unless and until dual method use becomes commonplace.

Recommendations

12. The MOH and Ministry of Local Government, Lands and Housing must agree to invest the time, effort, and funding in an intensified effort to create clinics of competence as quickly as possible. This will require releasing trainers and trainees more frequently, and may temporarily exacerbate the shortage of staff. It is important to emphasize, therefore, that the longer term effect will be to improve the quality of care in a crucial area. Consider all of the following: a) training more trainers b) taking trainers out of their clinic jobs and assigning them to training full time; reactivating the other two training sites and running more than two courses simultaneously; filling the clinic positions with expatriates c) creating a shorter course to improve the knowledge and counseling skills of enrolled nurses and general nurses who can provide basic family planning counseling and services and improved STD counseling.
13. An advanced training of trainers course should be held in-country for the Central Training Section and Training Resource Group to consolidate their learning, and to focus on an experiential module on FP/STD/HIV counseling that includes assertiveness coaching about a woman's right to protect herself. This will prepare the Training Resource Groups to help nurses and midwives work more effectively with their clients on

dual-method use.

14. A nurse midwife master trainer should be contracted for six months to a year of technical assistance to the Central Training Section.
15. In order to apply the Syndromic Approach to diagnosis and treatment of STDs, it is very important for service delivery providers to have accurate information about the treatments that have been tried and have not worked. Thus record-keeping and access to records takes on additional significance. The new Family Planning Card should have adequate space on it, or an attachment to it, to inform providers at different clinics about the treatments that have been tried so that they know which treatment should be initiated on a follow-up client from another clinic.
16. The MOH should consider, as a policy question, whether IUD insertion should be carried out by certified staff only. The BOTSPA training could be used as a certification program, as it includes the important elements of STD counseling, STD diagnosis and treatment, and family planning counseling as well as the clinical practice necessary to develop insertion skills.
17. Even though USAID is no longer active in the population sector in Botswana, there are many agencies that were developed and supported by USAID, and that are very experienced in working with programs around the world that have challenges similar to those in Botswana. We encourage the GOB to take advantage of the experience of other countries and to contract with Cooperating Agencies for assistance in areas such as:
 - * Community-based distribution (CEDPA, Washington, DC)
 - * Management and strategic planning (Family Planning Management Development Project at Management Sciences for Health, Boston, MA)
 - * Technical training in counseling (AVSC in New York, PCS (Johns Hopkins) in Baltimore, MD),
 - * Curriculum revision (American College of Nurse-Midwives in Washington, DC)
 - * Logistics and MIS (Family Planning Logistics Management Project at John Snow, Inc., Boston).

4.3.4 Management Information Systems and Logistics

4.3.4.1 BOTSPA II MIS Objectives

One of the major components of BOTSPA II was strengthening the management information system (MIS) of the national MCH/FP program at all levels in order to obtain better quality data

collection and utilization. The 1991 midterm BOTSPA evaluation found that

- ? Data collected on family planning performance were often of poor quality and untimely; they were seldom used for program management.
- ? The program lacked quantifiable objectives, and providers and managers did not know how to use data adequately to demonstrate progress.
- ? Data analysis at the central level generally was done too late to be useful.
- ? Providers and district health teams received little or no feedback on data they submitted.
- ? Health providers still needed considerable training in the accurate completion of family planning recording forms, stock control reports as well as overall inventory management.

The BOTSPA II Project was designed to address these deficiencies. Goals for 1994-1996 are

- ? Train more MCH/FP service delivery providers in the operations and use of MIS, and continue the refinement of the MIS training curriculum.
- ? Revise, finalize, and distribute the Family Planning Logistics Manual (originally drafted with the assistance of CDC) to all facilities.
- ? Consider the modification of the SWEDIS software program at the Central Medical Stores to be able to monitor distribution to districts.
- ? Compile a family planning MIS reference guide (handbook/manual) to include procedures and forms for recording data, and calculating and graphically displaying specific indicators of the FP program performance for use at national, district, and facility level.

The project plans also called for the family planning guidelines and procedures to be expanded in order to enable MCH/FP providers and managers to improve the forecasting of commodity requirements and monitoring of stock levels throughout the logistics system. Also, the MOH was to develop specific MIS guidelines for the training and use of each level of service delivery and management.

4.3.4.2 Training of Service Providers in MIS

BOTSPA II set a goal of training 305 family planning/STD service providers in MIS/logistics as well as familiarizing about 105 FP/STD supervisors with the system.

Results of Training. To date, the BOTSPA Project has trained 30 nurse/midwife trainers (the Training Resource Group - TRG) and 73 nurse/midwives in MIS/logistics, using the curriculum developed and refined by the MCH/FP Unit with assistance from the Cambridge Consulting Corporation.

On its site visits, the evaluation team found uneven results of the training. Some members of the team found good results in knowledge and application of the training in some of the health facilities visited; others found less than satisfactory results in other facilities. In some cases, it appeared that the training had produced a considerable motivation factor, with impressive graphs of couple years of protection (CYPs) and contraceptive prevalence rates posted on the walls of the clinic.

Without many more site visits, the evaluation team was unable to come to a general conclusion on the effectiveness of the training or the training curriculum. A better judgment should be possible after completion of the training follow-up currently being undertaken by the Training Resource Group.

However, the Situation Analysis of June 1995 found that the level of reporting from health clinics on family planning data had improved considerably over the situation existing in 1991, before the project started; and that there were very few stock-outs of commonly used family planning items.

The MIS/logistics curriculum is being refined, and a revised version was issued by the MCH/FP Unit in June 1996. Further revisions may be considered following its evaluation by the Training Resource Group.

The evaluation team felt, however, that whereas the training curriculum should continue to give an overview of indicators such as CYP and CPR, there seems less justification for busy MCH/FP providers in health clinics to spend time producing these. Such calculations would not be much use to them, when seen in isolation; more important would be their production and use by District Health Teams and the MOH.

Recommendations

18. The service provider training, which includes an MIS/logistics component should be continued and indeed accelerated, to try to cover all MCH/FP service providers by the end of 1997. District Health Teams should also be included in this training.

19. The MIS/logistics component of the training should place more emphasis on accurate data collection and reporting, and on the use of data on new and continuing acceptors for program assessment and planning, as well as in commodities forecasting and requisitioning.
20. Instruction in CPR and CYP calculations and their application should continue to be included in District Health Team training; DHTs should be encouraged to develop these indicators and use them for monitoring and motivation purposes in their districts. However, health service providers should be only introduced to these indicators and understand their relevance to overall program assessment; they should not be compelled to do the calculations at the health facility level.

4.3.4.3 Family Planning Logistics Manual

The BOTSPA II plans called for the review and revision of the 1989 Logistics Manual, "Managing Family Planning Commodities and Drugs in Botswana," in order to include procedures for forecasting commodity requirements and monitoring district stock levels and to take into account recommendations made by a Center for Disease Control/John Snow, Inc. consultancy report of August 1992. It appears to the evaluation team that the 1989 Logistics Manual has not been revised and re-published, and therefore this output has not been achieved.

However, in August 1995 a Cambridge Consulting Corporation consultant, quoting a Family Health Division survey, estimated that in 1993, some 74 percent of health facilities were still in possession of the unrevised handbook.

Recommendation

21. The Logistics Manual should be updated, printed, and distributed as soon as possible.

4.3.4.4 MIS Family Planning Handbook

The MIS Family Planning Handbook/Manual is still not finalized. The Cambridge Consulting Corporation consultant who visited in June 1996 recommended that "the MIS Handbook should only be developed after there is agreement between the Central Training Section, Research and Evaluation, family welfare educators, and other FHD units on the level of technical specificity of the contents and benefits to be gained in the field by targeted users." MCH/FP managers are expecting the Cambridge Consulting Corporation to reformat the MIS Handbook into a pocket edition before the end of the project.

Recommendation

22. The MIS Family Planning Handbook/Manual should be finalized, produced and distributed to all MCH/FP facilities as soon as possible.

4.3.4.5 Monitoring of Commodities Distribution

Since 1988, the MOH Central Medical Stores (CMS) appear to have performed increasingly well in ensuring a constant and sufficient supply of family planning items and STD drugs to health facilities. However, three factors are posing financial and operational difficulties for CMS:

- ? Lack of adequate up-to-date data on actual consumption at health facilities. Its procurement is based upon historic average monthly distribution dating back more than six months. More accurate data would enable CMS to use more cost-effective procurement procedures.
- ? Volume of orders. CMS must respond within one month to requisitions from some 550 clients.
- ? Soaring costs. The cost of drugs and family planning items requisitioned from CMS by health facilities are increasing at an average of 22 percent per year, which is placing a strain upon CMS's budget and ability to supply. Some of this increase is believed to be due to a liberal practice of prescribing expensive drugs for treatment of STDs.

Despite these difficulties, CMS has generally managed to keep pace with the nation's medical supply needs. In some cases (e.g., condoms), CMS's procurement reflects the increasing emphasis on STD/HIV prevention. Supplies ordered in 1994/95 will provide the country with about 15 months of stock at present rates of distribution.

Although work is currently under way, CMS has not been able to modify/expand its software in order to provide MCH/FP managers with data on actual distribution of FP items by district. It seems that this output, planned under the BOTSPA Project, will be accomplished soon through other means⁴.

For the family planning logistics system to become sustainable and avoid severe breakdowns, several measures are urgently needed: the level and speed of data provided to CMS from the facilities and district health teams needs to be improved, and prescribing practices and choice of drugs need to be changed (there should be more use of generic drugs). Strains are already showing; CMS received only 40 million Pula for its procurement budget for 1996/97 instead of the 50 million Pula it had requested. However, CMS must do its part by providing distribution

data to districts on a regular basis as soon as its software can be adapted.

Recommendations

23. MCH/FP service providers, both in the MOH and Ministry of Local Government, Lands and Housing, need to work more closely with the Central Medical Stores to share information on contraceptive stocks, needs, and future requirements, as well as the costs of procurement and distribution. To facilitate budgeting and planning, the Central Medical Stores should inform all providers of the costs of the various family planning commodities in advance of the distribution cycle.
24. A nationwide inventory of family planning stocks should be made by the end of 1996 based on the Monthly Report Forms. Any excess stocks should be removed and redistributed; expiration dates should be checked, and new procurements should be adjusted as necessary.
25. The Central Medical Stores distribution to health facilities should be better organized and reported to district health teams. CMS should distribute supplies every two months at most; district stores should be more widely used as buffer depots for health facilities; and district pharmacy technicians and other health management personnel should be included in MIS/logistics training so that they can make more use of family planning usage data.

4.3.4.6 Existing Deficiencies in the MIS/Logistics System

Under the BOTSPA Project, the MOH has made considerable progress in developing and institutionalizing a functioning and effective MIS and logistics system. For example, the MCH/FP reported that at least 75 percent of expected family planning monthly reports were being sent in to the MOH headquarters and that almost 100 percent were, after some "cleaning up" of data, ready to be tabulated and analyzed (1994 MCH/FP Annual Report, 1996).

Nevertheless, some areas of the system remain weak, and some of the quantifiable objectives have not been achieved. Among the existing deficiencies are:

1. Lack of accuracy. There is still considerable variation in the standard of reporting data from health facilities which makes the accuracy of the completed data questionable in some cases and in need of a "clean up" (Report of MCH/FP Research and Evaluation Section, 1994).
2. Processing delays. Data processing at the central level (MOH Medical Statistics and MOH Research and Evaluation Section) is often delayed due to the heavy workload and

other factors, such as computer breakdowns.

3. Lack of data use by managers. Managers at district and central levels do not make sufficient use of service statistics to monitor progress and performance and to make timely management decisions.
4. Lack of inputs into commodities orders. Health providers have no input into CMS ordering and distribution procedures of family planning commodities. This separation adversely affects program management: Family Health Division and MCH/FP managers cannot monitor the performance of CMS and assess cost-effectiveness; the ability of CMS to forecast accurately and procure family planning and STD requirements is hampered; and the Ministry of Local Government, Lands and Housing lacks a clear vision of the program's performance and cost-effectiveness.
5. Overemphasis on CYP. The program emphasizes CYP, while giving less attention to the numbers of contraceptive users and contraceptive prevalence. Service statistics could be strengthened by inclusion of financial data, such as cost of contraceptive supplies by district.
6. Need for coordination. More coordination between the District Health Teams, MCH/FP providers, and the ordering/supplies staff at CMS would reduce the possibility of delays in distribution, overstock and understock situations, expired goods, and overspending.
7. The present MIS appears adequate for collecting basic data on new and repeat acceptors, amounts of family planning commodities distributed, and stock/requisition levels. It does not, however, provide for the collection and analysis of client-specific data that could be used to assess program trends in areas such as continuation rates, method switching, and clinical treatments. This weakness should be considered in the forthcoming review of MCH/FP report forms.

The present MCH/FP MIS and logistics system needs to be further refined, developed, and used at all levels before it can be an effective management tool to support better MCH/FP service delivery.

Recommendations

26. More analysis of the Monthly Report Forms could be made by the District Health Teams, the MCH/FP Unit, and Central Medical Stores rather than passing them directly to the MOH Health Statistics Unit (HSU) without review. Service statistics could be better used in developing strategies and managing programs. Currently, data on contraceptive usage are not forwarded to the Central Medical Stores for use in forecasting, ordering, or

budgeting. The Health Statistics Unit should compile the data in a timely manner and distribute it to the various tiers of the service delivery system and to CMS.

27. The Research and Evaluation Section should report MCH/FP program statistics on a quarterly basis. Such reports should include the number of new acceptors, CPR, CYPs, method mix as well as the costs of family planning supplies. However, these indicators should and could be developed primarily by District Health Teams. If necessary, district data clerks should be hired/trained for this purpose, and the data sent to MCH/FP every month, as well as used for performance/motivation purposes at the health facility level.
28. The Family Planning Register, which is used to record new acceptors, could be reduced to half its present size if the section for future appointments were condensed.
29. The Monthly Report Forms combine outpatient diagnoses with MCH/FP data. The forms should be redesigned so that data on different contraceptive methods will not be added together; data for condoms should be recorded separately. Also, more information on the specific drugs used to treat STDs would be helpful.

Without timely, accurate service statistics, it is impossible for program managers to determine trends in family planning acceptors and method mix, estimate future needs, and calculate realistic budgets. Weak oversight could lead to the development of out-of-stock situations, low morale among health providers, and possibly heavy inventories of slower-moving items in health facilities as well as in CMS, and thereby increase costs.

4.3.5 IEC Materials for Family Planning and STD Prevention

4.3.5.1 IEC Activities under BOTSPA I

The original BOTSPA Project agreement signed in July 1988 included extensive IEC activities in support of MCH/FP services. The activities that were implemented during 1988-1991 were short- and long-term IEC training for MOH staff; family life education workshops for NGOs; equipment purchases for print and radio production; production of a poster, a leaflet, four booklets, and two videos; and distribution of purchased videotapes. An expatriate IEC advisor funded under BOTSPA worked in the MOH during 1989-1991. Two counterparts were recruited but remained in their positions only a short time; they were not replaced.

Activities planned but not implemented during 1988-1991 included the use of mass media for family planning promotion; a male motivation campaign; provision of audiovisual equipment to districts; pilot tests of alternative media channels; integration of IEC into the training of non-health extension workers; and development of family life education materials for use in schools (Bertrand et al., 1992, p. 26-30).

4.3.5.2 Planned Activities and Outputs under BOTSPA II

In light of the IEC implementation problems experienced during the first phase of the BOTSPA Project, the scope of IEC activities planned for the second phase was greatly reduced. The Project Paper for the redesigned BOTSPA Project stated that it would "focus solely on specific IEC materials to support clinical services, including counseling." (PP Supplement, Sept. 1992, p. 28).

According to the project plans, the MOH Health Education Unit, MCH/FP Unit, and an external consultant hired by the Cambridge Consulting Corporation were supposed to

- ? "Conduct focus-group research to fill gaps in current KAP data regarding specific reasons for non-use and discontinuation, as well as knowledge and attitudes regarding STDs? their causes, symptoms, effects, prevention, and relation to AIDS. . . .
- ? Review current family planning materials from the perspective of potential use in clinics? such as counseling aids and sources of information useful to clients (chiefly mothers with children, but . . . also adult men and teenagers of both sexes).
- ? Design, test, and produce copy-ready drafts of new IEC materials. . . ." (PP Supplement, Sept. 1992, p. 28-29).

Examples of FP/STD materials given in the Project Paper Supplement were "fact sheets on condoms, pills, injections, IUDs, and the management of their side effects" and "material for women to use to discuss family planning with their husbands." The purpose of the materials was "to communicate the value of spacing and delaying first pregnancies; counter misconceptions and promote acceptance, correct use, and continuation of family planning; and promote recognition, treatment and prevention of STDs." (PP Supplement, Sept. 1992, p. 29) The IEC materials were to be completed prior to the start of the training courses for service providers.

4.3.5.3 Outcome

In December 1994, the Cambridge Consulting Corporation funded a U.S.-based IEC consultant with extensive experience in Africa to review available research studies and print materials on family planning and STDs. The consultant concluded that existing research provided adequate information for formulating IEC strategies, thus implying that focus group research to fill in gaps in KAP data was unnecessary. The consultant further concluded that existing materials on family planning and STDs were adequate but were not distributed widely and used by service providers and health educators. In consultation with the Health Education Unit (HEU), he recommended that the BOTSPA Project concentrate on strengthening the ability of health

educators to develop motivational activities.

The IEC consultant's recommendation to support training rather than materials production was accepted by all those involved in the BOTSPA Project: the MCH/FP Unit, the Health Education Unit, MLGLH's Primary Health Care Unit, the Cambridge Consulting Corporation's resident technical advisor, and USAID/Botswana. Accordingly, the project embarked on a new initiative to train IEC trainers and family welfare educators who are community-based outreach workers.

The IEC consultant's report provides no details regarding the studies and materials he reviewed. His report does not discuss how the specific needs identified in the Project Paper Supplement were to be met or which materials could be used to support counseling on family planning and STDs.

Some of the decision-makers may have been misinformed about financial arrangements. The IEC consultant points out that the BOTSPA Project has no funds to produce materials and that the Health Education Unit has limited funds for materials production. However, the Project Paper Supplement states that "Mass production and distribution will be a GOB responsibility." (PP Supplement, p. 29).

It seems likely that the determining factor in dropping materials production as a project activity was the lack of staff in the Health Education Unit to undertake materials preparation and pretesting. Staff attrition and extended absences for overseas training have reduced the Health Education Unit's staff from its peak of 19 in mid-1993 to 12 in late 1994. Today, the Health Education Unit has a staff of seven, including two health education professionals, a radio programmer, three graphic designers, and a water education specialist. The Health Education Unit is expected to meet the IEC needs of the entire MOH and thus covers a wide range of health issues. The Project Paper Supplement lists the following as the Government of Botswana's inputs: the work of counterparts within HEU, the MCH/FP Unit, and the National AIDS Control Programme. Clearly, these inputs were less than had originally been planned and precluded an intensive materials production effort.

4.3.5.4 IEC Training

The IEC training component was added in December 1994. It had two phases:

- ? Two four-week TOT workshops that trained 15 nurses and other staff to be master trainers, known as IEC Promoters; and
- ? Several two- to three-week training courses that have trained 155 family welfare educators to date.

Both TOT and Family Welfare Educator courses devote roughly half of the training time to IEC program planning. Only three of the IEC Promoters are responsible for this task in their regular work. Family welfare educators have neither the education nor the professional stature to conduct research, design messages, and plan IEC campaigns.

Given the range of responsibilities already assigned to family welfare educators and the short time allocated for off-site training, it would be more practical to limit their training to skills that they use every day, such as counseling clients on method use and potential side effects, conveying information effectively to individuals and small groups, responding to questions, and making referrals.

IEC planning is most effectively performed at the national and district levels. At present, IEC planning is lacking at all levels. Training low-level field staff to do conceptual work that should be done higher up in the system cannot compensate for this missing element and is unlikely to lead to better community education work. In sum, it is not clear that BOTSPA-funded training will improve the family welfare educators' job performance, and materials to support client counseling and education are still lacking.

Recommendation

30. The training curriculum for family welfare educators should be reviewed to ensure that the content is consistent with their current duties, skills, and knowledge. Alternative formats such as local training and supportive supervision should be explored. The Central Training Section should follow up the IEC Promoters and family welfare educators trained in IEC to determine what elements of the IEC training they have found useful in their everyday work and what skills need strengthening.

4.3.5.5 Current Status of IEC Materials on Family Planning and STDs

It is true that many print materials have been prepared in Botswana. However, these materials only partially meet the objectives of the BOTSPA II Project[?] as identified in the 1992 Project Paper Supplement[?] to have materials on FP/STDs to support client counseling and community outreach.

Based on an analysis of print materials currently available from the Health Education Unit and NGOs, some gaps remain unfilled:

- ? Handouts for new contraceptive acceptors;
- ? Flip charts and other materials for clinic talks and outreach; and

? Materials specifically directed to men.

Many of the materials currently distributed require good reading skills; some are more than 10-years old and need to be updated. Appendix F provides more details.

Very few audiovisual materials in English or Setswana are available, despite the availability of audiovisual equipment in district council offices and hospitals.

4.3.5.6 Distribution of Print Materials

Although the Cambridge Consulting Corporation's IEC consultant recommended in 1994 that print materials be more widely distributed, this goal has not been systematically pursued.

The Health Education Unit conducted a study of health education/IEC materials in 1994. Nearly half (45 percent) of the health workers surveyed said that they did not receive adequate supplies of materials. One in five health workers said that some health materials were difficult to understand; family planning materials were among the content areas named as difficult.

The 1995 Situation Analysis of the MCH/FP program found that 35 percent of new family planning clients and 20 percent of repeat clients were exposed to IEC materials during their consultation. Samples of contraceptive methods were the most commonly used IEC material. Only six percent of the new family planning clients and two percent of the repeat clients reported seeing a brochure or leaflet. Only 30 percent of the health facilities surveyed had any flip charts on family planning; 58 percent had family planning pamphlets. Group health talks were held at only 15 percent of the facilities; 22 percent of these talks covered family planning or HIV/AIDS. Forty percent of the facilities had no brochures or pamphlets on HIV/AIDS.

The Health Education Unit, which is the major source of print materials for health facilities, recognizes that distribution systems are weak, but it lacks the staff and resources to improve them. It distributes a list of available materials to the districts once or twice annually. The districts either send a truck to collect materials or depend upon staff visiting Gaborone to pick up materials from the Health Education Unit and the AIDS/STD Unit. District staff may limit the quantities of materials they order due to lack of storage space. They have no routine method of distributing publications to the hospitals, clinics, and health posts in their jurisdiction. (All medical supplies are delivered monthly directly to service sites by the MOH Central Medical Stores.)

In theory, service providers can order unlimited quantities of print materials: The Health Education Unit provides them free of charge and does not restrict quantities. In practice, however, the system discourages generous distribution of materials to clients/patients or

community members: submitting orders creates additional paperwork, deliveries are erratic, and storage space is limited.

Recommendation

31. The MOH should explore with the Central Medical Stores the possibility of delivering audiovisual and print materials with regular medical supplies. IEC materials should be ordered in the same way as supplies. If this distribution mechanism is not possible, the Health Education Unit should set up a regular delivery schedule to the major health service providers. An order form listing available materials should be issued monthly to all health facilities. Samples of new materials should be distributed as they become available. Each quarter, facilities that have not placed an order should be contacted and reminded of the availability of materials.

4.3.5.7 Lack of Central-level IEC Functions

Few IEC activities have been conducted over the past four years. The situation remains the same as it was described in the 1992 Project Paper Supplement:

"Institutional support for FP/IEC is operationally weak. . . Some research has been conducted but not exploited. Distribution of IEC materials to health facilities and use by service providers is weak." (PP Supplement, 1992, p. 15).

Not only was the production of the few print materials planned under BOTSPA II canceled, but also alternative activities such as improving distribution of print materials and expanding radio coverage were not adopted. The alternative plan of strengthening the IEC skills of community educators cannot compensate for weak central IEC planning and inadequate IEC support. In fact, the lack of clear guidance on appropriate messages and materials to share with clients makes the task of community educators even more difficult.

The inability of the MOH to produce and disseminate print materials to provide adequate support to the BOTSPA Project is symptomatic of the larger and more serious constraint to effective IEC for family planning and STD programs. At the central level, the near-total absence of IEC in all aspects of MCH/FP program planning and implementation is striking. MCH/FP managers define IEC in terms of leaflets to be dispensed to unmotivated consumers, rather than as a central tool to accomplish program goals. The lack of IEC is seen as a lack of staff with materials production skills, rather than a lack of strategic vision.

Following are some of the central-level IEC functions needed to support family planning and STD services:

- ? Strategic planning. Based on a review of available research, managers should develop ideas about the critical problems (e.g. high contraceptive discontinuation rates, under-utilization of health facilities) and plan interventions to address these problems. Virtually all interventions have an IEC component. For each intervention, target audiences need to be identified. Messages and media channels are then selected based on the needs of each target audience.
- ? Media relations. Most people in Botswana name radio as their major source of information about family planning. Yet radio coverage of family planning and other reproductive health issues is minimal. The MOH should be actively seeking to increase media coverage of these issues and to correct misinformation. For example, Radio Botswana repeated a British Broadcasting Corporation story that Depo-Provera causes women's hair to fall out. The MOH did not challenge this report or seek to reassure the public of the safety of this method.
- ? National campaigns. A central office can decide on the major health-related behaviors it wishes to change and develop multifaceted campaigns to address them. National campaigns have more scope for defining normative behaviors (e.g. those needed for HIV/AIDS prevention) and reaching large numbers of people. Local campaigns and interpersonal contacts can expand the breadth and depth of national campaigns, but they are seldom effective substitutes for bringing about widespread behavior change.
- ? Client education materials. It is most cost-effective for a central office to meet the need for audiovisual and print materials to support counseling and outreach. Appropriate client education materials can greatly reduce the time needed for individual counseling and education. They can also promote more effective and consistent contraceptive use and prevent discontinuation due to fears and transitory side effects.

In planning interventions with IEC components, program managers need to focus on the audiences to be reached and the behaviors to be changed. Some managers seem puzzled by the paradox between research findings indicating high awareness of contraceptive methods and the peril of AIDS and the evidence that people do not seem to be changing their behavior in response to this awareness. The reason for this seeming discrepancy is that behavior change is often a long process in which the individual learns about the new behavior, discusses it with others, decides to take action, tries the new behavior, and ultimately decides to adopt it on a regular basis.

Many factors affect an individual's willingness to adopt behaviors that will reduce the risk of contracting HIV/AIDS or becoming pregnant. These factors include denial of the potential consequences of unprotected intercourse; social norms regarding male-female relationships; peer pressure; fear of medical treatments and contraceptive side effects; embarrassment; shyness; and

difficulties in obtaining the necessary information, counseling, and services.

To understand these factors better, program planners need to learn more about the perceptions of key audiences. Focus group discussions and other research methods can be used to investigate specific problems such as a reluctance to visit clinics (which might be based on long waits, inconvenient hours, hostile treatment by providers, fear of pain, unfamiliarity with the range of services offered, or other factors that can be corrected or addressed through IEC activities). Such research can be used to develop specific IEC messages and to identify the most appropriate media to reach each audience.

Program managers should not assume that print materials and didactic approaches will be more effective in changing behaviors than indirect methods. Recent experience in many countries has shown that entertainment has tremendous potential to educate people and change behaviors related to reproductive health. Music, comedy, and drama attract people's attention, engage their emotions, and provide role models for socially desirable behavior.

More innovative approaches are needed to reach men and youth² two groups that are not adequately reached through clinic services. Workplace peer education programs reach employed men. To reach unemployed men, managers need to explore the use of radio, community groups, and outreach by NGOs. In-school youth are reached through family life education programs, peer educators, and school groups led by NGOs. Out-of-school youth are reached by the Botswana Social Marketing Program promotional events, peer educators, radio, and NGO activities. These activities need to be expanded and intensified to address the AIDS pandemic and teenage pregnancy.

Given the existing staffing constraints in the MOH, program managers need to take a careful look at the possibility of contracting for specific IEC services. Potential contractors include advertising, public relations and research companies, graphic design studios, radio stations, NGOs, the University of Botswana, and independent consultants. Given the urgency of the AIDS crisis, some outside sources may be willing to provide their services at a reduced cost or for free. Fees should always be negotiated, rather than accepted without question.

By using outside contractors, the MOH can expedite the development and production of materials, while maintaining control over their content and format. Contractors tend to produce high-quality, creative work, or they could not stay in business. Contractors that do not perform well can be discharged without the cumbersome procedures needed to remove regular employees from their posts. Typically, contractors are motivated to complete their job in an expeditious manner in order to be paid; the industrious employee is rewarded mainly by being given more work (or perhaps a promotion to non-IEC work).

Recommendations

32. Managers of reproductive health programs should initiate a strategic planning process that includes interventions with IEC components. These strategies should be consistent with overall (national-level) strategies developed by the Ministry of Finance and Development Planning. The ministry should then devise a workable system for accomplishing key IEC tasks. Such a system should include the involvement of NGOs and other government agencies as well as contracting for outside services as needed.
33. The MOH should add at least one IEC specialist to the reproductive health team. MOH managers should work with the IEC staff to ensure that careful attention is given to identifying problem areas, developing strategies to address them, analyzing target audiences, and designing and testing appropriate messages. Managers should seek to meet the needs of target audiences and promote changes in behaviors related to reproductive health. A variety of media channels and interpersonal sources should be explored; print materials may not be effective with all audiences.
34. MOH implementing agencies should consider using NGOs and the private sector in order to obtain state-of-the art strategies and materials and to expedite the materials production process.

4.3.6 Research and Evaluation

4.3.6.1 Research Funded by USAID

Three major research initiatives have been funded by USAID since 1990:

- ? Male and Family Planning Survey. With support from the BOTSPA Project, the National Institute of Development Research and Documentation of the University of Botswana conducted a national survey of male knowledge, attitudes, and practices regarding family planning and AIDS. Conducted during 1990-91, the survey provided in-depth information about condom use, beliefs regarding AIDS, and paternity. Three major groups of men aged 13-69 were surveyed: a) 1,984 males in households; b) 1,575 males in 48 educational institutions; and c) 600 males in the military and prisons (Kgosidintsi and Mugabe, 1994).
- ? MCH/FP Situation Analysis Study. In June 1995, the MOH MCH/FP Unit studied the services and counseling provided in a random sample of 186 health facilities nationwide. The Population Council Operations Research/Technical Assistance Project provided funding and technical assistance for the Situation Analysis. Section 5 of this report summarizes the key findings. Findings of the Situation Analysis are being used to develop indicators of the quality of care and to develop tools for assessing providers'

skills.

- ? Adolescent Health KAP Surveys. The Condom Social Marketing Project, managed by Population Services International and funded under BOTSPA II, conducted two KAP surveys of youth aged 13-18 in two major urban areas during 1994 and 1995. (See Section 4.4 for more details.)

4.3.6.2 Other Relevant Research

Other major sources of data on reproductive health KAP and trends are

- ? The 1991 Census, conducted by the Central Statistics Office with partial funding from the UNFPA, provided a wealth of data on social and demographic trends.
- ? The Family Health Survey III is currently being conducted among a national household sample of reproductive-age women. With a long gap since the last Family Health Survey in 1988, this survey will provide much needed information on contraceptive prevalence and unmet need for family planning. Unfortunately, the survey does not include men, and women will not be asked about double method use (condoms plus a female contraceptive method) or use of condoms for STD/HIV/AIDS prevention.
- ? Several KAP surveys of youth in urban and rural areas have been made by the National AIDS Control Programme. These studies focus on sexual behavior and knowledge of AIDS risks.
- ? The 1990-93 UNFPA-sponsored pilot project on vital registration in four districts may also yield data that will be useful in reproductive health research.

4.3.6.3 Use of Research in Program Planning

Lack of up-to-date information on contraceptive use and fertility trends has hindered program planning and evaluation. With the initial findings of the Family Health Survey III expected in late 1996, this situation should be rectified.

Research capability is generally very good in Botswana; the FHS III is being conducted without outside assistance. However, research findings are sometimes not used in developing new strategies and programs. For example, the 1990-91 male survey findings, which were printed in 1994, were not used in developing new IEC initiatives for men; by now the findings are becoming outdated. Also, plans for research findings and final reports could be shared more widely among relevant institutions in order to avoid duplication and to exploit the findings as

much as possible.

Recommendations

35. Managers of reproductive health programs in all relevant government agencies and NGOs should make greater use of research findings in developing program plans and strategies.
36. The Research and Evaluation Subcommittee of the National Council on Population and Development should collect, evaluate, and disseminate research findings to all interested parties. Strategies for integration of recommendations into ongoing and planned programs also need to be developed.
37. A survey of males is needed to determine the prevalence of condom use and use of condoms in conjunction with another contraceptive method. The Central Statistics Office should explore the possibility of adding this component to a household survey that is already planned, if it is too late to add it to the Family Health Survey III that is currently under way.
38. The preliminary findings of the Family Health Survey III should be disseminated as rapidly and extensively as possible.

4.4 Condom Social Marketing

4.4.1 Project Overview

The redesigned BOTSPA II Project included support for subsidized condom sales as a measure to combat the rapidly growing spread of HIV/AIDS and thus promote better reproductive health. The Botswana Social Marketing Program (BSMP) had four major objectives:

- ? Sell more than 2 million condoms within three years;
- ? Achieve broad distribution of the Botswana Social Marketing Program condom brand in all urban and commercial centers as well as nontraditional commercial outlets such as bars, hotels, and workplace sites;
- ? Train and develop a local distributor; and
- ? Conduct an aggressive promotion and advertising campaign that would generate awareness and motivate purchase of the BSMP condom brand.

Implemented by Population Services International under a contract with USAID/Botswana, BSMP was designed to complement the activities of the MOH National AIDS Control Programme.

The Botswana Social Marketing Program activities began in November 1992. The project developed a brand of condom, a distribution system, a promotion campaign, and set up an office.

The product, Lovers Plus condoms, was officially launched in June 1993. The Botswana product has the same name as the one that PSI sells in South Africa, but it was selected after careful pretesting. It is sold in a three-condom pack for 50 thebe (US\$0.15) per pack.

In September 1995 PSI established a local NGO, known as PSI/Botswana. This organization now runs condom social marketing activities with technical assistance from PSI headquarters. PSI's resident advisor plans to leave Botswana in October 1996; PSI is believed to be recruiting a replacement in Washington.

BOTSPA funding ended in March 1996. Since then, the Government of Botswana has continued to provide PSI/Botswana condoms with the Lovers Plus packaging free of charge. The GOB has also provided PSI/Botswana with a grant of approximately US\$242,000 to meet one year's recurrent expenses (through March 1997).

4.4.2 Condom Sales

Sales of the Lovers Plus pack have more than exceeded expectations and targets. During 1993, one million condoms were sold. Sales reached 1.2 million condoms in 1994 and two million in 1995. They are projected to reach at least 1.7 million in 1996. (Sales fell in the first half of 1996 because of a product recall due to concerns about the quality of one consignment.) Within its first two years of operation, BSMP exceeded its three-year target of two million condom sales. As of April 1995, per capita sales of Lovers Plus condoms were higher than any other socially marketed condom in the world.

4.4.3 Distribution

Today the Botswana Social Marketing Program condoms appear to be widely and easily available through many types of retail and nontraditional outlets throughout the country. The Lovers Plus brand is available in about 2,000-2,500 retail outlets nationwide. These outlets include bars, general stores, liquor stores, hotels, pharmacies, wholesalers, private physicians, market stalls, hair salons, cooperatives, and gas stations. The recommended retail price of 50 thebe (US\$0.15) per pack of three condoms seems to have been maintained in most cases, though there are reports of prices as high as 75 thebe.

The Botswana Social Marketing Program has achieved the objective of identifying, training, and motivating a key distributor. An estimated 90 percent of Lovers Plus sales have been made through Ya Rona, which is a major wholesaler/distributor to other wholesalers and major retail outlets. It has offices/depots in Gaborone and Francistown. Based on interviews and records of repeat orders, the evaluation team found that Ya Rona has moved the condoms onwards to its 40 wholesalers and 235 retail accounts throughout the country. Consumer sales maintain a reasonable momentum. From January 1994 through July 1996, Ya Rona estimates that revenue from the Lovers Plus condom was US\$84,800, which accounts for 80 percent of BSMP's revenue during the project period.

Sales through the country's principal pharmaceutical distributor have not been as high, mainly due to the lower profit margin in selling Lovers Plus compared with commercial brands of condoms. Commercial brands sell for roughly 2 Pula (US\$0.60) per condom, yielding a profit margin of 2-3 Pula (US\$0.60 to US\$0.90) per pack of three. The BSMP price makes Lovers Plus easily acceptable to most potential customers, especially males and youth. This customer group represents an important target for the national campaign against HIV/AIDS, since they are not easily reached through health clinics.

The BSMP sales force appears to have been successful in supporting the supply and distribution of the major wholesaler Ya Rona. To date it has opened some 700 retail outlets through personal visits and sales promotions.

4.4.4 Promotion and Advertising

The BSMP has used various types of trade promotions to build brand loyalty among distributors, wholesalers, and retailers. In addition to offering premiums, temporary price reductions, and promotional materials, BSMP has used peer educators in wholesale and retail outlets to educate people about Lovers Plus. BSMP has set up product displays at major trade shows and other public events.

During 1994 and 1995, BSMP conducted the "It's My Life" campaign, which aimed to make condom use a regular part of the buyer's contemporary lifestyle. The campaign stressed specific behavior changes that could prevent HIV/AIDS and other STDs, including limiting partners, resisting pressures to have sex, discussing HIV and condoms with partners and friends, and learning to negotiate condom use. The campaign messages were featured in a song, print and radio advertisements, T-shirts, and promotions.

Peer education? youth reaching other youth? is the cornerstone of BSMP's behavior change initiatives. BSMP sales staff set up a booth in a public place and discuss condom use as a crowd gathers. Up to 350 people a day may be reached in this way. BSMP also organizes larger sessions featuring dance, music, contests, and drama to entertain audiences that may range in

size between 500 and 2,500 people.

Since May 1995, BSMP has sponsored a weekly radio show that is carried nationally. Young people call in with questions and comments. BSMP also recorded songs promoting Lovers Plus and used them in radio spots. It also advertises in magazines and distributes calendars, T-shirts, and other promotional materials.

BSMP's promotional activities may have stimulated the demand for free condoms in the government health facilities as well. The quantity of condoms distributed by health facilities has greatly increased since 1994/95. Since most of these condoms are given out without any printed information on correct use, BSMP's peer education activities and packaging may be meeting the needs of these consumers as well.

4.4.5 Consumer Research

BSMP conducted formative market research to test prototype advertisements among in- and out-of-school youth, various occupational groups, and literate and illiterate audiences. In March 1993, it collaborated with the National AIDS Control Programme in conducting a baseline study of knowledge, attitudes, and practices (KAP) related to sexual behavior among youth. A follow-up KAP study was conducted in February 1996.

As part of its Adolescent Reproductive Health project, BSMP conducted a baseline KAP study among adolescents aged 13-18 in two urban areas (Francistown and Lobatse) in mid-1994. Following a campaign to encourage youth to seek more information and visit health facilities for counseling and reproductive health services, BSMP conducted a follow-up survey in late 1995.

BSMP also conducted consumer intercept studies in December 1993 and December 1994 to learn more about consumers and their preferences.

4.4.6 Costs

BSMP's total budget under BOTSPA II was US\$1,242,000 between November 1992 and March 1996. It also received US\$115,000 in revenues from condoms sales. Taking into account the total project cost and the cost of the commodities donated by the GOB, the cost per couple year of protection (CYP) comes to US\$54. (The total cost to USAID was US\$40 per CYP.) These costs are very high relative to other condom social marketing programs in Africa and to other contraceptive methods available in Botswana. For example, in 1992 PSI reported that its programs in Africa cost an average of US\$25 per CYP, and some countries had achieved costs as low as US\$11 per CYP. Most social marketing programs experience high start-up costs, but BSMP's costs seem much higher than other countries.

BSMP costs could be expected to be somewhat higher due to the long distances and relatively sparse population distribution. Also, sales potential may be reduced by the availability of free supplies of condoms in government health clinics throughout the country.

Also, it should be kept in mind that the project's main objective is to prevent HIV/AIDS transmission and therefore a different cost-benefit ratio may apply, given the devastating human, social, and economic costs associated with AIDS. PSI estimated that BSMP had averted roughly 22,000 cases of HIV infection by February 1995.

4.4.7 Sustainability

Clearly, BSMP is far from self-supporting. Its costs far exceed sales revenues and it currently depends on the GOB's one-year grant (from April 1996 through March 1997) of US\$242,000 to pay for recurrent expenses. Future funding prospects are uncertain.

Prospects for BSMP's continued operations could be enhanced through a combination of cost-cutting and revenue-increasing measures. Budget areas in which economies are likely to be possible include advertising and promotion, research, travel and transportation, and salaries and fringe benefits. The heavy costs of product launch, establishing distribution channels, and survey research are not needed to maintain current sales levels. Also, since the project has been transferred to local management by PSI/Botswana, there may not be an urgent need for a resident expatriate advisor.

The evaluation team estimates that BSMP would need revenues of at least US\$120,000 annually to cover a minimum level of marketing, promotion, and administrative costs. The current level of sales? around 2 million condoms annually? generates gross revenues of about US\$60,000 per year at current prices. BSMP has several options for bridging the gap:

1. Government support. PSI/Botswana would need funding of at least US\$60,000 a year plus continued supplies of free condoms with the Lovers Plus packaging.
2. A doubling of sales. If condom sales could be doubled, revenues would also double. However, it is unlikely that sales of this level could be achieved. Sales in 1996 appear to be flattening out as wholesale/retail outlets begin to be filled and as the government supply of free condoms in health facilities appears to become a major access point.
3. A price increase. If the retail price of Lovers Plus were raised to one Pula (US\$0.30) per packet of three condoms, BSMP's revenues would double to US\$120,000 annually and thus would cover its basic expenses. The Lovers Plus brand currently costs a fraction of its major competitors such as Durex. A retail price of one Pula (US\$0.30) may be

acceptable to most potential customers (a bottle of beer costs 1.80 Pula, or US\$0.55). Changes in pricing may need further study and testing.

4. A second, higher-priced product. A second, premium-priced condom would achieve better profitability. However, a new product would entail high launch costs and could reduce some sales of Lovers Plus.
5. The introduction of additional products, such as oral contraceptives, should only be considered after careful study of market potential, pricing, and financial and management implications.

These options are not exclusive and may be combined to achieve the best effect possible. However, they must be combined with the economy measures mentioned above, as well as the provision of free condoms provided by the GOB. (The GOB may be able to reduce the purchase price of the Lovers Plus brand condoms, which is currently some 50 percent higher than the GOB's own condoms, probably due to the packaging material in which Lovers Plus is supplied. Supplying in bulk and doing the packaging locally may prove more economic and should be studied.)

4.4.8 Risk Factors

However, BSMP may take note of certain risk factors (exposures) which have become apparent. These include

1. About 90 percent of BSMP's condom sales are made to and through only one wholesaler. Should any calamity befall that wholesaler (e.g., fire, bankruptcy) or should there be serious disagreement between the parties, the project would be in trouble.
2. All supplies of condoms at present come from one supply source, the Central Medical Stores (CMS). Though these supplies are free, they could be affected by problems between CMS and its suppliers as occurred in late 1994 and early 1995. These led to out-of-stock situations and had a negative effect on sales. This problem will become acute again in August 1996 when stocks will be completely exhausted for one or two months, making it almost impossible for BSMP to reach the revised 1996 sales target of 1.7 million condoms.
3. The massive distribution of free condoms through government health facilities may begin to undercut the sales of Lovers Plus condoms; this is not to imply that the GOB should cease to distribute free condoms.
4. The low retail margin on Lovers Plus condoms may cause retailers to sell more expensive

brands.

Recommendations

39. The Botswana Social Marketing Program should continue its operations to support national HIV/AIDS-prevention efforts and promote better reproductive health. However, with the ending of USAID funding, it should seek to become more self-supporting and cost effective through a combination of cost-cutting and revenue-producing measures. BSMP should continue its promotional activities, since it provides essential information to populations at risk of HIV/AIDS and STDs. It should also continue to receive free supplies of condoms from the Central Medical Stores.
40. BSMP should examine the factors that put the program at risk (discussed above) and take appropriate action.
41. Certain management functions in the Botswana Social Marketing Program should be strengthened, especially the management information systems that cover a) product inventories and distribution performance by district and by outlet; and b) better accounting data on activities and expenditures.
42. Efforts to seek alternative funding after April 1997 should be intensified and widened.

4.5 NGOs and the Private Sector

4.5.1 Overview of NGO Component of BOTSPA II

The NGO component of the BOTSPA II Project was designed to strengthen the planning, management and evaluation capabilities of NGOs that are actively involved in reproductive health and HIV/AIDS prevention, especially among youth. The long-term impact was expected to be limited to a small number of NGOs, but the project was envisaged to have a potential for providing useful lessons and experience that could be replicated in the future.

To manage the NGO project, USAID/Botswana contracted with the Population Council to strengthen the capacity of NGOs involved in reproductive health, especially youth activities. The contract was a buy-in to the Population Council's Africa Operations Research and Technical Assistance (OR/TA) Project for US\$481,745.

The NGO project consisted of a series of technical assistance inputs, workshops, and operations research activities to

1. Provide training to NGOs in problem identification and proposal development;
2. Provide general management training to NGOs, including training in program planning, development, implementation, evaluation, and communication and dissemination; and
3. Assist NGOs to develop relevant, feasible, and cost-effective long-range strategies.

The Population Council identified a local agency to implement the NGO project:

- ? The Botswana National Productivity Centre (BNPC), which is a local management training and consulting parastatal organization, received a subcontract for US\$231,850 to implement the management training component. The BNPC's role was to design, organize, and facilitate training workshops, data collection and management, technical assistance for project management, and other services.
- ? The MOH Health Research Unit (HRU) was asked by the Botswana National Productivity Centre to undertake the operations research and problem-solving component of the project.

The Botswana National Productivity Centre provided a team leader for the project and four part-time consultants. The MOH Health Research Unit provided two full-time staff and two part-time consultants to serve as principal investigators in the operations research study. The Population Council recruited a local resident advisor to coordinate project activities and provided technical assistance and back-stopping services from its Africa Regional Office in Nairobi, Kenya.

Although the project was originally planned for 18 months, delays in finalizing the necessary contracts resulted in the project starting seven months late. Thus, only 11 months (November 1995-September 1996) were left to implement the project. The limited time for implementation was a major constraint and needs to be taken into account in assessing the progress and potential impact of this component of BOTSPA II.

4.5.2 NGO Management Training

The Botswana National Productivity Centre identified potential NGOs to be involved in the project from those identified as working in family planning as well as members of the Botswana Network of AIDS Service Organizations (BONASO). Thirteen NGOs have attended at least one project workshop, and 11 NGOs have actively participated in the project, exceeding the original target of six NGOs. The 11 most active NGOs are

- ? AIDS Action Trust (ACT)
- ? Association of Medical Missions for Botswana (AMMB)

- ? Botswana Council of NGOs (BOCONGO)
- ? The Botswana Family Welfare Association (BOFWA)
- ? Botswana Girl Guides Association
- ? Botswana Red Cross Association (BRCS)
- ? Botswana Scouts Association
- ? Botswana Youth Centre
- ? Mambo Arts
- ? Population Services International/Botswana (PSI)
- ? The Young Women's Christian Association (YWCA)

Kick-off Workshop. After learning more about the project, 11 NGOs agreed to participate. The 30 workshop participants agreed on the name "Youth Empowerment Project" and planned three activities: 1) creation of a database of local resources involved in the delivery of reproductive health services to the youth; 2) mapping the physical location of reproductive health services operations; and 3) a plan for an operations research project to implement services and outreach.

Retreat Workshops. Between February and April 1996, nine 2-3 day retreat workshops were held to identify the technical assistance needs of individual NGOs. A joint workshop was held for the Botswana Council of Nongovernmental Organizations (BOCONGO) and YWCA, since BOCONGO has only one staff member. Each workshop developed a tailor-made plan of action for technical assistance and other management activities for each NGO. Each NGO's management problems practices were discussed; strengths, weaknesses, opportunities and constraints were documented.

The NGOs recommended that technical assistance and training under the BOTSPA Project should address four areas that were identified as common weaknesses:

- ? Strategic management planning
- ? Management of change and time
- ? Performance management
- ? Project management

These four topics became the focus of management development workshops held for NGOs. Three of the four management development workshops have been implemented. The fourth is scheduled for late July 1996.

The three management development workshops held so far are

1. Strategic Management Workshop. Nineteen representatives from eight NGOs attended this workshop, which was designed to assist NGOs to develop long-range plans. The three-day workshop provided an overview of the strategic planning process as well as

practical application. The NGO representatives did improve their skills in this area, but to date none of the participating NGOs has developed a strategic plan.

2. **Change and Time Management Workshop.** Twenty-eight representatives from 10 NGOs attended this three-day workshop, which was to assist them in managing change and time more effectively. The workshop covered key areas of change management, including performance and change of leadership, followership choice, change situations and the human factor in change management as well as better use of time.
3. **Performance Management Workshop.** Twenty-five representatives of nine NGOs attended this three-day workshop, which was designed to orient them to personnel management and improve individual performance.

Appendix H lists the NGO workshops and attendance by NGO representatives.

4.5.3 Training in Operations Research

The MOH Health Research Unit planned to conduct two workshops to assist NGOs to plan and implement operations research. A workshop on research proposal development was held in February 1996. The second workshop, which is on data analysis and report writing, is scheduled for August 1996.

Research Proposal Development Workshop. Organized by the Health Research Unit in collaboration with the Botswana National Productivity Centre, this two-week workshop was attended by 23 participants from nine NGOs. The workshop covered health systems research and the development of a research proposal, including the problem definition, objectives, literature review, methodology, budgeting, work plan, and administration of a research project. Because most of the participants were high school graduates with no previous experience in research, the course content was simplified to match their skill level. Furthermore, many took a long time to grasp research principles and also had problems with the language of instruction, especially with sentence construction. This led to delays in completing research proposal writing within the workshop period and subsequent activities which needed to have been completed before the scheduled data analysis and report-writing workshop. In particular, the data collection, data entry and cleaning process now had to be done in a much shorter time than was anticipated.

Participants had to complete proposal writing outside of regular working hours. Hence, the first proposal was not completed until early June 1996. To date, five Operations Research projects are in various stages of implementation. All five research proposals were approved for funding. Of these, four are in the data collection stage and the fifth has completed data collection and is awaiting data entry, cleaning, and analysis.

Data Analysis and Report Writing. The Health Research Unit staff and the consultants have been working with the NGO staff on developing the proposals, questionnaires, pretesting the questionnaires, sampling, and supervising data collection. Data coding in preparation for computer entry and processing, data entry, and data cleaning are planned for late July prior to the Analysis and Report Writing workshop which is scheduled for August.

4.5.4 Achievements of NGO Training under BOTSPA II

Despite its short duration, the NGO Strengthening Project met most of its objectives: NGOs were trained in problem identification, proposal development, and program management. The project did not lead NGOs to develop long-range strategies, although the skills they learned may be applied in the future.

To date, 214 representatives of 13 NGOs attended 14 workshops during 1996 (some representatives attended more than one workshop). Two more workshops are planned before the project ends. Five operations research projects have been initiated and should be completed by September 1996.

Beyond its concrete accomplishments, the project laid the foundation for improved, expanded NGO activities in reproductive health/STD/AIDS. It raised NGO awareness of the need for capacity-building at the management level. The ability of NGO staff to discuss management issues signifies the beginning of team work, accountability, and transparency. The project also brought NGOs together for collaborative planning and networking. If these new practices continue, they will help NGOs to avoid duplication of efforts and inefficient utilization of resources.

4.5.5 Tasks for the Future

The NGO Strengthening Project started the process of preparing NGOs to take on expanded roles in the provision of reproductive health services and outreach. Future support of NGOs should take into account the following lessons:

- ? Need to train NGO executive staff and board members in leadership. In evaluating the impact of the BNPC workshops, nine NGOs were visited and the team found that about half of the trainees in these organizations stated that their supervisors did not allow them to implement their new skills. The Botswana National Population Council and the Health Research Unit trainers and the evaluation team believe that continued management orientation for consensus building should start with top NGO managers and board members in order to instill a supportive climate for change. This can then be followed

with training which must include both management and service personnel.

- ? Need to accommodate varying skill levels. Some of the trainees lacked the academic background to benefit from the workshops. Both the Botswana National Population Council and the Health Research Unit resource persons had to revise and simplify their materials and spend extra time to tutor participants. If the project timetable were not so tight, this would not have been a serious problem since, given sufficient time, any reasonably literate NGO staffer could benefit. Nevertheless, it would seem that in the future it would be useful to establish participant selection criteria to ensure participants' background and abilities are better matched to the training content and timetable. One possibility after BOTSPA would be to establish a TOT course for selected persons from the NGOs to enable some of those trained to establish in-house training for other staff and volunteers.

Based on lessons learned and the fact that the GOB's draft National Population Policy has identified enhancement of NGOs as one of the strategies for expanding and diversifying reproductive health programs, including family planning/STD/AIDS, the evaluation team suggests the following actions.

Recommendations

43. The process of strengthening NGO capacity and capability to provide quality reproductive health care and other social welfare services should be continued beyond the life of the BOTSPA Project to sustain and consolidate what has been achieved through BOTSPA. It is important that this be done before current enthusiasm and momentum among NGOs is lost. Further, consolidation of the NGO strengthening activities should include the following:
 - (a) Leadership orientation for consensus building and training for NGO executives and board members to prepare them to channel the skills of their staff and resources to a more planned reproductive health outcome;
 - (b) Follow-up to the BOTSPA strategic management workshops in the form of technical assistance to help develop strategic plans, address weaknesses and strategic issues identified in the workshops; and technical assistance in incorporating reproductive health elements into the strategic plans; and
 - (c) Use established NGOs (i.e., those with strategic plans and that are applying performance management approaches) and local and international donor agencies to maintain a high momentum in consensus building for continuous application and updating of performance-based management approaches.

44. Strategic plans should include emphasis on information and services for youth and men.
45. In all areas, women need to be encouraged to take control of their health and fertility by gaining skills in negotiating the use of condoms with husbands and partners. Strategic planning should take account of this need.
46. The NGO strengthening project should be redesigned to tailor the capacity building activities to the strategic plans referenced above. The redesign should include reproductive health service delivery, including outreach, community-based distribution, and IEC as component parts of the deliverables.
47. Operations research projects initiated by the NGOs during the BOTSPA Project should be supported to allow them to continue, and the NGOs should be encouraged to utilize the findings to strengthen their programs and strategic planning.
48. NGOs depend on donor funding almost exclusively, and this funding is being withdrawn as donors leave Botswana. It is therefore crucial that the government and the remaining donors consider providing financial and other resources that are sufficient to allow NGOs to develop their capacities further to complement GOB programs in reproductive health and other priority areas.
49. Given the need and the government's desire to involve NGOs in reproductive health initiatives, and the difficulty for the government in dealing with numerous NGOs, the GOB should explore the possibility of encouraging the development or strengthening of a grant-giving umbrella NGO.
50. An NGO umbrella organization, as described above, should be supported financially by the government and interested donors, and be provided with adequate resources, personnel, office equipment, etc., to enable it to provide capacity building and technical assistance to NGOs, and to liaise with the government and donors on behalf of NGOs.

Some key areas in which technical assistance may be provided to NGOs include the coordination of NGO plans, reports, and research activities prior to their submission to the government and to donors. Areas of need emphasized by the NGOs visited during this evaluation included technical assistance in monitoring and evaluation, operations research, management, organizational development, leadership and NGO governance, NGO networking, development of strategic plans, resource mobilization and specific technical areas such as reproductive health, gender, youth programs, and civic education.

51. In regard to moving forward quickly in reproductive health work by the NGOs, the government should consider earmarking a substantial sum (e.g., three to five million

Pula, exclusive of the BNPC) to be used for NGO strengthening in reproductive health service delivery, including HIV/AIDS/STD, to complement government efforts in this high priority area. Initial activities should include developing and documenting policies, plans, and activities in reproductive health.

4.6 Workplace Education

4.6.1 Workplace Initiatives Funded by USAID

The Botswana HIV/AIDS Prevention in the Workplace Project was conducted by the Occupational Health Unit (OHU) of the MOH Community Health Services Division during 1990-93. Funded by USAID with regional funds for an estimated US\$160,000, the project was designed to establish HIV/AIDS-prevention programs to reach men in the workplace. Since USAID funding ended in 1993, the project has been funded by the European Union.

The Occupational Health Unit project has trained 800 peer educators who provide HIV/AIDS education and distribute condoms in more than 100 industries. The project produced a handbook for managers, brochures and posters, which have been distributed. The project task force is comprised of representatives of the Occupational Health Unit, the Botswana Federation of Trade Unions, Botswana Defence Force, and the Red Cross. The Occupational Health Unit collaborates with the National AIDS Control Programme.

4.6.2 Other Workplace Initiatives

The MOH Occupational Health Unit supports a second workplace education project funded by UNFPA. During 1990-92 the project supported family planning education. During 1993-95, a service delivery component was added to enable Worker Educator Distributors (WEDs) to distribute pills and condoms in the workplace. The project was planned to cover Botswana's four largest cities. To date, 70 work sites have participated in the project. The project has trained 30 Worker Educator Distributors as well as 42 family welfare educators, who will assist with the supervision and training of Worker Educator Distributors.

The Botswana Confederation of Commerce, Industry and Manpower (BOCCIM), an NGO that represents private-sector businesses, has encouraged its members to initiate AIDS awareness activities in the workplace. Of its 1,500 members, 500 companies have initiated AIDS awareness programs that include educational talks by peer educators.

Subsequent to its involvement in the USAID-funded Workplace Project, the Botswana Federation of Trade Unions (BFTU) developed its own program. The Botswana Federation of Trade Unions, whose 19 affiliated unions have a combined membership of 12,000, assists eight

large companies with AIDS education activities. Funded by the South African AIDS Training Program, the Federation trains peer educators, negotiates with employers to designate full-time coordinators of AIDS-prevention programs, and seeks to protect employees from discrimination due to HIV/AIDS.

4.6.3 Consolidation of Workplace Programs

Workplace programs provide an important means of reaching employed men, especially since this group is not well reached through existing health facilities. However, such programs face many challenges in Botswana: employers rely on the public-sector health facilities to provide family planning services to their employees; supervisors are reluctant to release employees to visit health facilities (which are only open during regular working hours); appropriate IEC materials for men are lacking; most work sites do not keep records of peer education activities and hence program impact is difficult to ascertain; and supervision of peer educators is inadequate. The existing workplace programs do not cover the public sector, therefore employees of the GOB are not covered.

The ability of the Occupational Health Unit to develop a strong workplace education program is hampered by the difficulty of two separate programs supported by two external donors. To make maximum use of personnel and funding, the two programs should be combined.

Recommendations

52. The two workplace education programs run by the MOH Occupational Health Unit should be consolidated into a single program that provides comprehensive reproductive health (family planning/STD/AIDS) services and education. All workplace programs should collaborate to develop a uniform set of educational materials and training manuals.
53. Through advocacy of senior government officials, the Occupational Health Unit should encourage employers to provide greater support to workplace education programs.
54. The Occupational Health Unit should decentralize management and supervision of work-based peer educators to work site level. This would enable the management of each work site to identify one of its shop stewards or other staff to be trained by the Occupational Health Unit supervisors, which would in turn reduce the work site supervision load on central OHU staff. It would also help to shift the cost of supervision from the MOH to the employers and would likely contribute to greater sustainability following termination of government and donor funding.

55. The Botswana Federation of Trade Unions in collaboration with the Botswana Confederation of Commerce, Industry and Manpower should aggressively intensify their efforts to sensitize workplace top and middle-level managers to support the project and contribute toward its long-term sustainability.
56. UNFPA and the European Union should continue to provide funding and resources to the Occupational Health Unit and other interested NGOs to support AIDS-prevention activities in the workplace. They should also coordinate their assistance better in order to avoid duplication and maximize program impact.

5. INTEGRATED REPRODUCTIVE HEALTH SERVICES

5.1 Access to Integrated Services

The mandate for integrating family planning with maternal and child health services was promulgated in 1984. In 1993, the GOB decided to integrate STD prevention, detection, and treatment services into MCH/FP services. The reproductive health policy adopted in early 1994 includes STD services as part of the total reproductive health package. The training component of the BOTSPA II Project was designed to facilitate the integration of STD services into MCH/FP (Baakile et al., 1996).

Little information about integrated services was available until the results of the 1995 Situation Analysis of the MCH/FP Program were released in June 1996. This study, which was undertaken by the MCH/FP Unit with technical assistance from the Population Council, covered a representative sample of 186 health facilities and included interviews with 451 health staff, 386 family planning clients, and 724 clients receiving MCH services.

The major findings of the Situation Analysis were:

- ? Availability of services. More than 95 percent of the staff said that they provide family planning and child welfare services at the facilities in the study; however, more than 30 percent were not providing STD/HIV and antenatal services.
- ? Trained service providers. Less than half of the facilities had a staff nurse midwife or an enrolled nurse midwife on duty in the MCH/FP section on the day of the survey, suggesting that staff who were providing these services had inadequate training to do so.
- ? Provider skills. More than 90 percent of staff had some training in child welfare and family planning; 66 percent had basic training in antenatal care and STD management; 23 percent covered HIV/AIDS management in basic training. Most staff had completed their training before HIV was a problem, but more than 60 percent had attended a refresher course where HIV/AIDS management was covered. Less than half of the family welfare educators, who are often the only service providers available at health posts, had training in antenatal care and STD management. Only 35 percent of the staff interviewed said that they perform a pelvic examination before providing oral contraceptives; 50 percent do so before providing IUDs.
- ? Provision of STD services. More than two-thirds (69 percent) of the health staff have attended a course that included STDs and HIV. However, fewer than half have attended courses that included the syndromic approach to STD treatment, which was introduced in 1992. Less than 25 percent of the service providers said that they perform STD screening

before providing any of the methods, including IUDs. Most of the staff do not ask questions about sexual behavior that could assist in a reasonable diagnosis of an STD and lead to an appropriate treatment and counseling for behavior change.

This study was done before the BOTSPA training for service providers began. However, BOTSPA trained 104 of the estimated 3,200 nurses and nurse midwives working in health facilities, and 170 of the estimated 700 family welfare educators. Thus, the situation probably has not changed much since 1995.

A Rapid Assessment Tool to evaluate reproductive health services in clinics was developed on the basis of the Situation Analysis and will be fielded within two months. It will provide an indication of whether the BOTSPA training has altered the delivery of integrated services. In any case, it is clear from the Situation Analysis that the vast majority of service providers are not prepared to deliver high-quality, integrated reproductive health services.

Since the mandate was given for integration of MCH and family planning, an additional requirement was made that HIV/STD counseling and treatment be included at the same time. Even if the service provider has the technical knowledge to deliver all of these services, the shortage of nurses in all clinics raises a serious question about the feasibility of providing all of these services in busy clinics that serve a large at-risk segment of the population.

5.2 Access of Men and Youth to Integrated Services

Health officials report that women are the main recipients of reproductive health services. Men visit health facilities mainly for curative services. Nevertheless, the number of condoms distributed by health facilities to men (as well as women) is growing. Factors that may limit men's use of health facilities include the need to visit the clinic during regular working hours, lack of a private waiting area, and lack of information on the range of services offered.

Similarly, studies report that young people do not seek reproductive health services at health facilities for various reasons: health facilities are open only during school hours; health providers may be unfriendly and unhelpful; the crowded waiting room may contain adults who know the would-be client; and young people may not perceive themselves at high risk of STD/HIV and pregnancy.

The Botswana Social Marketing Program conducted an adolescent reproductive health project, known as "Tsa Banana" (For Youth), in Lobatse, Botswana's third largest city. The project used mass media and peer educators to promote shops that provide information and counseling as well as referrals to health facilities. Two-thirds of the youth aged 13-18 who were interviewed said that they had heard of the Tsa Banana activities, and 15 percent of these respondents went to a Tsa Banana shop. Of the 15 percent, nearly half were referred to a health facility, and half of these actually went to the clinic (Population Services International, June 1996). This project shows that young people will seek information and services when it is offered in a comfortable setting.

Offering reproductive health services at special hours for men and (separately) for youth could increase use of such services and might encourage early treatment of STDs. Orienting clinic staff to the needs of these special groups and making the clinic setting as welcoming as possible would also help. These changes need to be combined with appropriate outreach and promotion.

6. MATERNAL AND CHILD HEALTH/FAMILY PLANNING PROGRAM SUSTAINABILITY

6.1 Support from UNFPA and other Donor Agencies

UNFPA has been a leading supporter of the Ministry of Health's reproductive health and MCH/FP program in Botswana over the past decade. It has supported several activities including some under the BOTSPA Project. UNFPA has provided

- ? Assistance in development of a National Population Policy and associated national IEC policy, coordination of donor activities;
- ? Technical assistance to the MOH MCH/FP Unit through one medical officer (MCH/FP) for the management and training section and one statistician for the Research and Evaluation Section;
- ? Support to training of doctors, nurse/midwives in MCH/FP service delivery, and contraceptive logistics;
- ? MOH capacity-building through training of trainers, support to community-based distribution and IEC programs, including international courses;
- ? Strengthening of NGOs, in particular, for youth programs;
- ? Provision of Botswana's needs for injectable contraceptives;
- ? Introduction of new family planning methods (NORPLANT?);
- ? Support of reproductive health services for men in the workplace through the MOH Occupational Health Unit; and
- ? Work to elevate the status of women.

UNFPA's New Five-year Country Plan

The GOB and UNFPA have indicated interest in the outcome of the BOTSPA final evaluation, since the information developed will be useful for planning inputs to UNFPA's next five-year country plan. The scope of work of the evaluation team called for appropriate recommendations for possible UNFPA and other donor support for MCH/FP, possibly extending to areas not previously assisted by BOTSPA interventions, but which may need

support.

Recommendations

57. **Technical Assistance.** A continuation of technical assistance is needed in several important areas.

Strategic Planning. The evaluation team recommends that technical assistance in strategic planning to the Ministries of Finance and Development Planning, Health, and Local Government, Lands and Housing continue to be a primary area of support of UNFPA.

Training and Coordination. One UNFPA-funded medical officer presently is posted in the MCH/FP Unit. She has a broad reproductive health mandate, with a particular focus on training and new method delivery (NORPLANT?). Training for cancer screening has also recently been started with UNFPA funding.

More support is needed in the areas of training and strategic planning. As an alternative to the above medical officer position, or to complement it, UNFPA should consider support for the following positions, which the evaluation team believes are essential to strengthening the MCH/FP program:

- a) Six-months technical assistance to the Central Training Service by a trainer nurse/midwife, and
- b) 12-18 months of a longer term technical advisor to work in the MOH, who will be specifically responsible for strategic planning, coordination, and integration of reproductive health within the Ministry, as well as with the Ministry of Local Government, Lands and Housing.

Management. UNFPA or an other donor should provide support for a management expert to work within the Ministry of Local Government, Lands and Housing as a reproductive health manager/coordinator, with a prime objective to support, promote, and coordinate the implementation of the proposed District Initiative (Section 7 and Appendix J). This position should be filled primarily by a management expert, with a good knowledge of reproductive health, especially the planning, implementation, and monitoring/evaluation of community-based activities.

IEC. Donors should provide short- and long-term technical assistance in IEC to support the shift to more strategic, audience-centered IEC interventions.

Management Information Systems. Continued UNFPA support for the Research and Evaluation Section should be considered for at least one to two more years. The technical assistance should focus on building up expertise and management capacity of local personnel to run this unit efficiently by the end of 1997, with appropriate data processing equipment. By this time, the standard of data processing and analysis should have developed to a level where MCH/FP management are provided with recent and regular data for program monitoring and planning.

All these positions should be filled by persons who not only possess the required technical skills but who possess the strategic vision necessary to raise the level and increase the impact of the national reproductive health program in communities.

Recommendations

58. Supplies.

- ? UNFPA's provision of the national needs of injectable contraceptives should still be considered in the future as demand for this method increases and as the Central Medical Stores' budget comes under increased pressure from the fast-growing national needs for drugs and medical supplies.
- ? UNFPA's services might also be considered for procurement of some contraceptive items on behalf of the Central Medical Stores, if it can be shown that costs would be lowered, with no compromise on delivery schedules (e.g., if orals can be procured at a lower cost through UNFPA than on the open market, this might be considered).
- ? Supplies of NORPLANT should be continued at least until the expansion phase of this new method is completed.

59. NGO and Private Sector. Support to youth, NGOs, and other target groups, (e.g., males), begun both under the BOTSPA Project and through UNFPA-financed activities, should be intensified. UNFPA support is recommended for:

- ? NGO and community-based distribution activities in the proposed new District Initiative for family planning, HIV/AIDS prevention;
- ? Assistance to NGOs to draw up technical proposals, develop strategic plans, and develop monitoring and evaluation procedures;
- ? Support to NGOs to assist women in strengthening negotiating skills in the use

of condoms, etc.; and

- ? Continuation of support for YMCA peer educators in HIV prevention, as part of the Botswana Social Marketing Program.

6.2 Financial Sustainability

A public health service is composed of many elements[?] such as staff, fixed facilities, utilities, supplies. To be sustainable, it must have adequate financing for all these elements. One of the most important, and most vulnerable at times of economic constraints, is the supply of medical equipment, drugs, and dressings. This supply must be constant and sufficient if a public health service is to function adequately.

Lack of supplies will not only prevent patients and family planning acceptors from receiving treatment and service, it will lead to an undermining of public confidence in the national health service. If there are no drugs or family planning supplies, people will stop going to government health facilities; this also means that other vital services will be affected, including immunization and nutrition.

In a country where diagnosis and treatment is practically free, as in Botswana, there is often less awareness and attention given to costs of medical consumables in health clinics and hospitals than in other countries, both in the minds of health providers and those receiving health care. In this situation, over time, habits of over-prescribing, irrational prescribing, and over-usage tend to develop. These habits can place an increasing strain upon the financial resources of the MOH and can lead to breakdowns in the system.

The MOH is well aware of strains developing in the system; it has actively participated in conferences, both national and international, on cost recovery and health financing. It has a section that is actively looking into all possibilities of making the health service more self-sustaining financially. The Central Medical Stores is faced with requisitions from health facilities that increase 22 percent a year, yet its budget is constrained. It had requested Pula 50 million for 1996/97, but received only Pula 40 million.

At a time when the GOB is making huge efforts to reduce the incidence of STDs and HIV transmission, adequate funding of large quantities of condoms and STD drugs is essential. Yet, these can impose additional financial strains upon a system where user fees are so low that they can only cover less than one percent of annual recurrent health costs. The Central Medical Stores indicate that two drugs alone, used mainly in treatment of STDs, now account for 30 percent of their total budget for drugs.

Unless measures to contain these escalating medical supply costs are taken soon, there may come a time when budgets will not be sufficient to cover them, and supplies, including STD

drugs and family planning commodities, will fail.

This problem can be approached from at least two sides: 1) cost reduction through more discriminating and rational prescribing (and better diagnosis) and more cost-efficient procurement (more use of generics); and 2) increasing revenue through more realistic patient fees.

Rational prescribing can be encouraged through such measures as adopting some of WHO's guidelines on the rational use of drugs, better training in clinical diagnosis, and patient management. More cost-efficient procurement can be encouraged by more use of the generic equivalent and less costly alternatives, including possible use of international organization supply services (e.g., UNFPA). Increases in revenue can be achieved through a more realistic level of patient fees.

Recommendations

60. The MOH should continue to look into measures to control costs of the medical supply system, as per examples mentioned above. The ministry should also consider adjusting the present levels of patient contributions to health as part of a comprehensive plan of action to preserve adequate supplies of essential commodities such as STD drugs and family planning items now and in the future.
61. The MOH Central Medical Stores and the Ministry of Local Government, Lands and Housing should carry out a nationwide survey of drug/family planning inventories in health clinics and hospitals, take back or redistribute any that are overstocked, and destroy or retest for possible further use of those that might have expired.
62. The Central Medical Stores should inform the two Ministries, in advance, of the costs of drugs, family planning items and other medical supplies distributed to their facilities.

6.3 Legal and Regulatory Issues

6.3.1 Prescriptions for Oral Contraceptives

Contraceptives should be easily available and accessible to all who wish to use them. Currently, in Botswana oral contraceptives are officially not allowed to be sold in private pharmacies without a prescription. In practice, this regulation is often disregarded, and the regulatory authorities at the MOH have so far taken a benevolent view of this. However, it appears (discussions with the Drugs Unit, MOH, July 12) that a regulation is in the drafting stage which would impose penalties on pharmacists for selling oral contraceptives (OCs)

without prescription.

If this regulation is put into effect, it would force private family planning users to revisit their doctors for a Pula 40 consultation plus the Pula 6 or more cost of a cycle of OCs every month. This would be a severe barrier to women who wish to obtain contraceptives in the private sector.

Recommendation

63. This draft regulation should be withheld until more study has been made into its possible negative effects on OC use. It is further recommended that OC refills be available to users in private pharmacies without the need for new prescriptions/consultations.

6.3.2 Drug Registration and Central Medical Stores Procurement

At present, all drugs, including hormonal contraceptives that enter and/or are on sale in the country, must be pre-registered with the Drugs Unit of the MOH. Because of backlogs at the Drugs Unit, this procedure can take up to 18 months.

The Central Medical Stores, however, may wish to buy certain items on tender, including FP items, which may not have been registered thus far in Botswana. Such items may be sourced from international organizations, such as UNFPA or IPPF, or from internationally recognized pharmaceutical manufacturers and may lower the costs to the CMS.

The standard of manufacturing and quality assurance of any new supplier can be verified through government to government contact (e.g., WHO Certification Scheme) or through personal inspection of facilities and references. Only then can there be a reasonable chance that the products purchased will be of good quality and correspond with the specifications of purchase. With any new supplier, comprehensive testing of samples should be carried out before confirmation of purchase. Strict specifications should always be established in advance.

Recommendation

64. The Central Medical Stores, in close consultation with the Drugs Unit of the MOH, should be able to purchase on tender those items it considers cost-efficient for the national health service. This should not depend on whether the items are registered in Botswana or not, as long as quality is not compromised. Suppliers of such items should be asked to demonstrate approval for good manufacturing practices in their

countries of origin and ability to carry out any possible orders within the required period of time. They should be urged to produce registration documentation and materials at an early stage to be evaluated by the Central Medical Stores and the MOH Drugs Unit before confirmation of orders.

Note: It may sometimes be overlooked that the production of a registration file and a smart-looking sample is not in itself a guarantee of quality or reputation of the supplier.

7. FUTURE DIRECTIONS

The Government of Botswana is in a strong position to move its family planning and STD/AIDS program forward by using many of the assets it has developed over the last 20 years of experience in family planning. Important gains can be made relatively quickly, especially if the priority of rapidly strengthening reproductive health programs is recognized in concept and put into action. The urgency of effective action to combat further STD/HIV transmission makes it imperative that hard decisions be taken to improve service availability now.

The democratic process and consensus building are values deeply entrenched in Botswana society. Sometimes, however, the need to overcome a real and present danger is so great as to call for inspired leadership and decision making. The evaluation team submits that the current situation with STD/HIV incidence and prevalence in Botswana, as described in numerous MOH and other documents, constitutes a deep and compelling national crisis² one in which the usual ways of getting things done may not be adequate, and in which the consequences of *not* getting the job done are unthinkable.

There is no longer time for slow-paced training (however high quality), for trickle-down and trickle-up on-the-job training, for government systems to carry out their work vertically, for public-spirited volunteers to go untapped, or services to wait passively at fixed delivery points for consumers to use them. It is now urgent that the Family Health Division (MOH) and the Primary Health Care Office (MLGLH) work together to develop a rapid large-scale incremental improvement in the training of all categories of service providers, and in their supervision and delivery of FP/STD/AIDS services.

In this section, the team has attempted to trace the outlines of an effective strategy to extend reproductive health services to as many people as possible in the shortest possible time. Components of the strategy include those which can be implemented immediately, within current policy and budget constraints, as well as those which will likely require raising the dialogue to a higher level.

Steps toward a strengthened reproductive health program should include:

1. MOH and MLGLH offices involved in reproductive health information and services must work together to develop a shared vision and strategic plan for the FP/STD/AIDS program for district level implementation. Planning should begin with gathering a core planning committee of identified leaders (senior matrons, medical officer, community health nurses, and other operational district staff) who have demonstrated their ability to effect change in a district service delivery system. The Family Planning Management Development Project at Management Sciences for

Health in Boston, MA, could provide experienced facilitation of the process.

2. Based on the vision and the strategic plan, relevant units in the Primary Health Care Division (AIDS/STD Unit, MCH/FP, Health Education Unit, Research & Education, Community Health) should define and develop interventions that will operationalize the plan.

Elements that should be included in the program are the following:

Leadership and Authority. The strategic plan should address the vital concerns of: a) leadership at the central and district levels; and (b) a sufficient level of program visibility and priority within the MOH and MLGLH to be able to cut through red tape and get the job done.

Training. A focused training program should aim to raise the quality of FP/STD/AIDS services across the board? not to full-service capability for a few service providers, but to a somewhat lower capability for all nurses and nurse midwives (see Section 4 for details). A training program should be developed for district supervisors and managers to enable them to oversee and monitor the service delivery system, using basic clinical and MIS skills.

IEC. The MOH should develop a more comprehensive program for IEC that includes central-level functions, community outreach and counseling. Central-level functions include strategic planning using research to identify key problems, audiences and behaviors; media relations to increase media coverage of reproductive health issues; national campaigns to influence health-related behaviors; and client education materials (see Section 4 for details).

Condom Social Marketing. The retail sales and promotional activities of the Condom Social Marketing Program should be supported. Innovative promotional activities to reach youth and other audiences should be encouraged.

MIS. Measures to improve the accuracy and timeliness of service statistics would help program managers at national, district, and local levels to identify weaknesses and correct them (see Section 4 for details).

Monitoring and Supervision. District Health Service teams must also develop operational plans and implement them for the family planning/STD/AIDS program which includes training and the supervisory support to implement new skills; monitoring and supervision of service delivery.

Community Outreach (Public and Private Sector). Education and demand-creation activities at the community level should be supported and encouraged in the nongovernmental and private sectors:

The GOB and donors should continue to provide financial support to the NGOs while long-term sustainability strategies are being developed.

The GOB should assist the NGOs to strengthen/initiate a coordinating body that would help them to develop technical proposals to submit to donors and negotiate funding with GOB and donors on behalf of all the NGOs in country.

What is Different? The recommended program outlined in the Future Directions section above differs from the current program in that it

- ? Requires collaborative strategic planning at the central level;
- ? Moves the locus of activity planning to the district level; and
- ? Integrates the critical components of FP/STD/HIV programs.

The evaluation team is convinced that an approach along the lines sketched above would have an important beneficial and lasting impact on provision of reproductive health care services throughout the country.

Putting It All Together: A District-Level Action Initiative. A district-level action initiative would provide a concrete example of actions needed to implement the national population policy. It would also serve as a basis for advocacy by program planners and NGO activists to demonstrate that an intensive program can have a wide impact within a relatively short period of time.

Rationale. A bold new initiative should be carried out at the district level to integrate the above elements and serve as a living laboratory for population policy implementation. Lessons learned and successes demonstrated in this effort should be rapidly disseminated to policy makers and health program managers, following which the action program should be replicated as quickly as possible in other districts throughout the country.

Purpose. The purpose of this initiative would be to: a) reach nearly 100 percent of the reproductive-age population in an entire district within one year, provide counseling and reproductive health services at the doorstep; and b) increase utilization of existing health services. Programmatic objectives should be to increase contraceptive prevalence by 100 percent in one year and interrupt the transmission of STDs, including HIV, within the focus area.

Program Elements. The public-sector portion of the action program involves using family welfare educators or other appropriate agents to carry out a systematic house-visiting program in which the goal is to reach every household with a package of counseling and services at

three-month intervals over a maximum period of one year. Non-clinical contraceptive methods (orals and condoms) would be provided at the doorstep, and referrals would be made to fixed facilities for clinical methods). Depending on results, a decision might be made to carry out a total of only two or three visits[?] in lieu of four visits[?] followed by an appropriate resupply and support scheme requiring far less intensive work (and personnel). Alternatively, if personnel are available and if desired, the services package provided by field workers might be expanded somewhat to include other preventive measures, and fieldwork continued on a somewhat less intensive basis (this was, e.g., what was eventually decided in Morocco, which now has 20-years' of experience with this sort of outreach).

Household Visits. At the time of each household visit, field workers would provide counseling in STD/AIDS prevention and in contraceptive methods and their use, including detailed instructions for use of oral contraceptives. For continuing users, they would ascertain whether the method is being used correctly, including counseling on use of dual methods (condoms for STD prevention where this is a risk, plus a more effective contraceptive method for fertility control where desired).

Role of Fixed Facilities. The fixed health facilities (and *mobile stops*) would play an important role in an outreach program, including:

- a) Serving as a ?home-base? for outreach workers, where they could gather periodically to review progress, exchange experiences and learn from one another, receive technical support, complete paperwork, resupply contraceptives, etc.; and
- b) Provide clinical services and higher level counseling to persons referred by field workers (perhaps even giving ?special handling? to clients who present a referral chit received from field workers to make them feel welcome).

Mobile stops could be used to put special emphasis on particular methods, e.g., injectables and possibly IUDs, as well as STD treatment and counseling, using outreach workers to rally clients to attend on scheduled dates.

Nongovernmental Component. The nongovernmental portion of the Initiative would be carried out by NGOs and private sector companies, targeting youth and men in appropriate locations (youth clubs and schools, and for men, workplace, bars, gathering places, etc.). NGO and private sector activities would be carefully planned to complement and mesh with public sector activities to achieve the overall goal of reaching nearly 100 percent of the reproductive-age population in the chosen geographic area (district).

Assertiveness Skills. In all project components (public sector, NGO, and private sector), special attention should be given to assisting women of all ages to enhance their assertiveness skills for negotiation in sexual relationships, especially as regards condom use by their

partners, and in promoting dual method use for those who wish to delay or avoid pregnancy.

Measuring Results. The initiative should include simple built-in quantitative measures, helping to document *on a near real-time basis* progress toward objectives and overall impact of the action program. For example, at the time of each house visit, each field worker would complete a simple form containing information on just five items:

- a) present use of contraceptives in household;
- b) desire to delay or limit additional births;
- c) contraceptives distributed to new users or resupplied to continuing users;
- d) referrals for clinical contraceptive methods; and
- e) referrals for STD treatment, antenatal or postnatal care, etc.

Simple quantitative measures would also be built into the nongovernment component of the initiative, allowing for aggregation of collected data with those provided by field workers and fixed facilities which will yield an overall view of impact.

Since household visits would be programmed to make one complete round of visits in a three-month period, there would be comparative data on project progress available for analysis every three months, helping managers and planners to refine project design and deal with unanticipated problems.

Further details of the proposed initiative are contained in Appendix J.

Recommendation

65. The MOH, the Ministry of Local Government, Lands and Housing, and the Ministry of Finance and Development Planning should work together to develop plans for an intensive outreach effort along the lines suggested above and in Appendix J. The temptation to launch such an effort in more than one district simultaneously should be resisted, since the level of effort required to do just one district properly will likely tax available staff resources heavily. Rather, concentration on one clear and unequivocal demonstration of success on a large scale (entire district) will allow the development and refinement of planning, management, implementation, supervision, coordination, IEC, and monitoring skills which can then be applied rapidly and effectively in other districts.

APPENDIX B

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List of Recommendations (in order of appearance)

1. Together with the Ministry of Finance and Development Planning, the MLGLH and MOH need to develop a clear vision and strategic plans for complementary, district-centered FP/STD Programs to operationalize population policy strategies.
2. Since services are delivered at the local level, district health managers (DHT and MOH) need to be the focus for developing and implementing operational plans for the FP/STD Program.
3. The level of authority for reproductive health/family planning in the MOH needs to be raised in the organizational structure to give sufficient attention for priority RH/FP/STD/AIDS needs. Similarly, the MLGLH needs to give appropriate importance to reproductive health in its management structure. Both ministries need to appoint full-time managers for the priority reproductive health program.
4. A supportive supervision process carried out by the DHT and MOH supervisors at each site should be adopted. The 'Triple-A Supervision Initiative', being carried out by the MLGLH and MOH, offers a model of site self-directed assessment, analysis and action that should be considered.
5. The future role, responsibilities, and objectives of the CTS need to be clarified and agreed. It is the judgment of the Evaluation Team that overall responsibility for the reproductive health program in the MOH would not be an appropriate role for the CTS, rather they should continue to be responsible for the FP/STD training.
6. Program strategies need to take into account the disruptive effects of the continuous changes in staffing due to transfer, local training, and long-term external training.
7. Programs that require timely scheduling, decision-making and problem solving, need to negotiate communication systems - telephone lines and faxes - and budgets to support them so that precious human resources are not squandered due to lack of negotiated simple solutions.
8. Training capacity should be expanded to train all service delivery nurses and nurse midwives and their immediate supervisors to deliver integrated FP/STD/HIV counseling and services.

9. The in-service training program should be redesigned and reduced to approximately 10-12 days (without IUD insertion practice) to achieve rapid coverage countrywide.
10. Due to the high prevalence of STDs, IUDs should only be inserted by nurse midwives whose technique in counseling, STD diagnosis and treatment, and IUD insertion have been certified acceptable.
11. IUD insertion training should continue as rapidly as the availability of clients and trainers permits.
12. A two-week advance TOT should be conducted for CTS and TRG staff to revamp the curriculum for a two-week course. The TOT should include an experiential module on STD/HIV/AIDS counseling that includes assertiveness coaching about a woman's right to protect herself. This will prepare the TRGs to help nurses and midwives work effectively with their clients.
13. The intensity of FP/STD/HIV training in the pre-service nurse and midwifery curricula should be heightened so that all new nurses can practice fully and confidently upon completion of their programs. Nursing tutors at the Institutes for Health Sciences should participate in the FP/HIV/STD intensive course described above to emphasize the importance of strengthening the pre-service curricula with integrated counseling and contraceptive technology. Until that is accomplished, a bridging strategy is to add the two-week program to the end of the pre-service curricula for midwives, nurses and to the upgrade program of the enrolled nurses, along with the AIDS/STD program, and enlist the CTS and TRGs to do the training.
14. To increase the output of pre-service nurse and midwifery programs, recruitment of expatriate tutors should be undertaken; and student housing should be constructed to accommodate larger numbers of students.
15. The service provider training, which includes an MIS/logistics component should be continued and indeed accelerated, to try to cover all MCH/FP service providers by the end of 1997. District Health Teams should also be included in this training.
16. The MIS/logistics component of the training should place more emphasis on accurate data collection and reporting, and on use of data on new and continuing acceptors for program assessment and planning, as well as in commodities' forecasting and requisitioning.

17. Instruction in CPR and CYP calculations and their application should continue to be included in District Health Team training; DHTs should be encouraged to product these indicators and use them for monitoring and motivation purposes in their districts. However, health service providers should only be introduced to these indicators and understand their relevance to overall program assessment; they should not be compelled to do the calculations at the health facility level.
18. The Logistics Manual should be updated, printed and distributed as soon as possible.
19. The MIS FP Handbook/Manual should be finalized, produced and distributed to all MCH/FP facilities as soon as possible.
20. MCH/FP service providers, both in the MOH and MLGLH, need to work more closely with the CMS to share information on contraceptive stocks, needs and future requirements, as well as the costs of procurement and distribution. To facilitate budgeting and planning, all providers should be informed by CMS of the costs of the various FP commodities in advance of the distribution cycle.
21. A nationwide inventory of FP stocks should be made by the end of 1996 on the basis of the Monthly Report Forms. Any excess stocks should be removed and redistributed; expiration dates should be checked; and new procurements should be adjusted as necessary.
22. CMS distribution to health facilities should be better organized and reported to district health teams. CMS should distribute every two months at most; district stores should be more widely used as buffer depots for health facilities; and district pharmacy technicians and other health management personnel should make more use of FP usage data. To facilitate this, they should be included in MIS/Logistics training.
23. More analysis of the Monthly Report Forms could be made by the District Health Teams, the MCH/FP Unit, and CMS, rather than passing them directly to the MOH Health Statistics Unit (HSU) without review. Service statistics could be better used in developing strategies and managing programs. Currently, data on contraceptive usage are not forwarded to CMS for use in forecasting, ordering or budgeting. The HSU should compile the data in a timely manner and distribute it to the various tiers of the service delivery system and to CMS.

24. The Research and Evaluation Section should report MCH/FP program statistics on a quarterly basis. Such reports should include the number of new acceptors, CPR, CYPs, method mix as well as the costs of FP supplies. However, these indicators should and could be developed primarily by District Health Teams. If necessary, district data clerks should be hired/trained for this purpose, and the data sent to MCH/FP every month, as well as used for performance/motivation purposes at health facility level.
25. The FP Register, which is used to record new acceptors, could be reduced to half its present size if the section for future appointments were condensed.
26. The Monthly Report Forms, which combine outpatient diagnoses with MCH/FP data, should be redesigned to clarify that data on different contraceptive methods should not be added together and that condoms should be recorded separately. Also, more information on the specific drugs used to treat STDs would be helpful.
27. The training curriculum for FWEs should be reviewed to ensure that the content is consistent with their current duties, skills and knowledge. Alternative formats such as local training and supportive supervision should be explored. CTS should follow up the IEC Promoters and FWEs trained in IEC to determine what elements of the IEC training they have found useful in their everyday work and what skills need strengthening.
28. The MOH should explore with the Central Medical Stores the possibility of delivering audio-visual and print materials with regular medical supplies. IEC materials should be ordered in the same way as supplies. If this distribution mechanism is not possible, the HEU should set up a regular delivery schedule to the major health service.
29. Managers of reproductive health programs should initiate a strategic planning process that includes interventions with IEC components. These strategies should be consistent with overall (national-level) strategies developed by the MOFDP. They should then devise a workable system for accomplishing key IEC tasks. Such a system should include the involvement of NGOs and other government agencies as well as contracting for outside services, as needed.
30. MOH implementing agents should consider using NGOs and the private sector in order to obtain state-of-the-art strategies and materials and to expedite the materials production process.
31. Managers of reproductive health programs in all relevant government agencies and NGOs

should make greater use of research findings in developing program plans and strategies.

32. The Research and Evaluation Subcommittee of the National Council on Population and Development should collect, evaluate and disseminate research findings to all interested parties. Strategies for integration of recommendations into ongoing and planned programs need also be developed.
33. A survey of males is needed to determine the prevalence of condom use and use of condoms in conjunction with another contraceptive method. The Central Statistics Office should explore the possibility of adding this component to a household survey already planned, if it is too late to add it to the Family Health Survey III that is currently underway.
34. The preliminary findings of the Family Health Survey III should be disseminated as rapidly and extensively as possible.
35. BSMP should continue its operations to support national HIV/AIDS prevention efforts and promote better reproductive health. However, with the ending of USAID funding, it should seek to become more self-supporting and cost-effective through a combination of cost-cutting and revenue-producing measures. It should continue its promotional activities, since they are providing essential information to the population at risk of HIV/AIDS and STDs, and should continue to receive free supplies of condoms from Central Medical Stores.
36. BSMP should examine the risk factors discussed above and take appropriate action.
37. Certain management functions in BSMP should be strengthened, especially the MIS covering: (a) product inventories and distribution performance by district and by outlet; and (b) better accounting data on activities and expenditures.
38. Efforts to seek alternative funding after April 1997 should be intensified and widened.
39. The process of strengthening NGO capacity and capability in providing quality reproductive health care and other social welfare services should be continued beyond the life of the BOTSPA project to sustain and consolidate what has been achieved through BOTSPA. It is important that this be done before current enthusiasm and momentum among NGOs is lost. Further, consolidation of the NGO strengthening activities should include the following: (a) leadership training for NGO executives and board members to

prepare them to channel their staff skills and resources to a more planned reproductive health outcome; (b) followup to the BOTSPA strategic management workshops in the form of technical assistance to help develop strategic plans, addressing weaknesses and strategic issues identified in the workshops; and ? technical assistance in incorporating reproductive health elements into the strategic plans.

40. Strategic plans should include emphasis on information and services for youth and men.
41. In all areas, women need to be encouraged to take control of their health and fertility by gaining skills in negotiating the use of condoms with husbands and partners. Strategic planning should take account of this need.
42. The NGO strengthening project should be redesigned to tailor the capacity building activities to the strategic plans referenced above. The redesign should include reproductive health service delivery, including outreach, CBD, and IEC as component parts of the deliverables.
43. Operations research projects initiated by the NGOs during the BOTSPA project should be supported to allow them to continue, and the NGOs should be encouraged to utilize the findings to strengthen their programs and strategic planning.
44. NGOs depend on donor funding almost exclusively, and this funding is being withdrawn as donors leave Botswana. It is therefore crucial that the Government and the remaining donors consider providing financial and other resources to NGOs sufficient to allow them to develop further their capacities to complement GOB programs in reproductive health and other priority areas.
45. Given the need and Government desire to involve NGOs in reproductive health initiatives, and the difficulty for the Government in dealing with numerous NGOs, the GOB should explore the possibility of encouraging the development or strengthening of a grant-giving umbrella NGO.
46. The NGO umbrella organization referred to above should be supported financially by the Government and interested donors, and be provided with adequate resources, personnel, office equipment, etc. to enable it to provide capacity building and technical assistance to NGOs, and to liaise with the Government and donors on behalf of NGOs.

Some key areas in which TA may be provided to NGOs include the coordination of NGO

plans, reports, and research activities prior to their submission to the Government and to donors. Areas of need emphasized by the NGOs visited during this evaluation included: technical assistance in monitoring and evaluation, operations research, management, organizational development, leadership and NGO governance, NGO networking, development of strategic plans, resource mobilization and specific technical areas such as reproductive health, gender, youth programs, and civic education.

47. In regard to moving forward quickly in reproductive health work by the NGOs, the Government should consider earmarking a substantial sum (e.g., three to five million Pula) to be used for NGO strengthening in RH service delivery, including HIV/AIDS/STD, to complement Government efforts in this high priority area.
48. The two workplace education programs run by the MOH Occupational Health Unit should be consolidated into a single program that provides comprehensive reproductive health (FP/STD/AIDS) services and education. Furthermore, the OHU should extend its workplace programs to public-sector employees, who currently do not have them. All workplace programs should collaborate to develop a uniform set of educational materials and training manuals.
49. Through advocacy of senior government officials, the OHU should encourage employers to provide greater support to workplace education programs.
50. OHU should decentralize management and supervision of work-based peer educators to worksite level. This would enable the management of each worksite to identify one of its shop stewards or other staff to be trained by OHU supervisors, which would in turn reduce the worksite supervision load on central OHU staff. It would also help to shift the cost of supervision from the MOH to the employers, and would likely contribute to greater sustainability following termination of government and donor funding.
51. The Federation of Botswana Trade Unions in collaboration with BOCCIM should aggressively intensify their efforts to sensitize workplace top and middle-level managers to support the project and contribute toward its long-term sustainability.
52. A refresher course should be organized for the workplace peer educators to strengthen their counseling skills and provide them with IEC skills for behavior change.
53. UNFPA and the EU should continue to provide funding and resources to OHU and other interested NGOs to support AIDS prevention activities in the workplace. They should also

better coordinate their assistance in order to avoid duplication and to maximize program impact.

54. **Technical Assistance.** A continuation of TA is needed in several important areas.

Strategic Planning. The Evaluation Team recommends that technical assistance in Strategic Planning to the Ministries of Finance and Development Planning, Health and Local Government, Lands and Housing continue to be a primary area of support of UNFPA.

Training and Coordination. One UNFPA-funded program officer is presently posted in the MCH/FP unit, with a particular focus on training and new method delivery (Norplant). Training for cancer screening has also recently been started with UNFPA funding.

The Evaluation Team believes that more support should be given to Training and Strategic Development. It therefore recommends that as an alternative to the above program officer position, or to complement it, UNFPA may wish to consider support to the following positions, which are felt by the team to be essential for the strengthening of the MCH/FP program:

- (1) 6-months Technical Assistance to the Central Training Service by a trainer nurse/midwife, and
- (2) 6-12 months of a longer-term technical adviser to work in the Ministry of Health responsible for coordination and integration of reproductive health within the Ministry, as well as with the Ministry of Local Government, Lands and Housing (MLGLH).

Management. The Evaluation Team also recommends UNFPA or other donor support for a management expert to work within the MLGLH as Reproductive Health manager/coordinator, with a prime objective to support, promote and coordinate implementation of the proposed District Initiative (Section 7 and Appendix J). This position should be filled primarily by a management expert, with some knowledge of reproductive health.

Management Information Systems. The Evaluation Team found that continued UNFPA support for the R&E section should be considered for at least one- to two more years. The technical assistance to be provided should focus more on building up the expertise and management capacity of local personnel to run this unit efficiently by the end of 1997,

with appropriate data processing equipment.

By this time, the standard of data processing and analysis should have developed to a level where MCH/FP management are provided with recent and regular data for program monitoring and planning.

All these positions should be filled by persons who not only possess the required technical skills but who possess the strategic vision necessary to raise the level and increase the impact of the national reproductive health program in the community.

55. **Supplies.** It is recommended that:

- ? UNFPA's provision of at least a part of national needs of injectable contraceptives should still be considered in the future, as demand for this method increases, and as Central Medical Stores' budget comes under increased pressure from the fast-growing national needs of drugs and medical supplies.
- ? UNFPA's services might also be considered for procurement of some contraceptive items on behalf of the Government of Botswana/Central Medical Stores, if it can be shown that costs would be lowered, with no compromise on delivery schedules.
- ? Supplies of Norplant should be continued at least until the testing phase of this new method is completed.

56. **NGO and Private Sector.** Support to youth, NGOs and other target groups, e.g., males, begun both under the BOTSPA project and through UNFPA-financed activities should be intensified. UNFPA support is recommended for:

- ? NGO and CBD activities in the proposed new District Initiative for FP, HIV/AIDS prevention;
- ? Assistance to NGO's to draw up technical proposals, develop strategic plans and develop monitoring and evaluation procedures;
- ? Support to NGO's to assist women in strengthening negotiating skills in the use of condoms, etc.; and
- ? Continuation of support for YMCA peer educators in HIV prevention, as part of the Botswana Social Marketing Program.

57. The MOH should continue to look into measures to control costs of the medical supply system, as per examples mentioned above, as well as to consider adjusting the present levels of patient contributions to health, as part of a comprehensive plan of action to preserve adequate supplies of essential commodities such as STD drugs and FP items now and in the future.
58. The MOH, Central Medical Stores, and MLGLH should carry out a nationwide survey of drug/FP inventories in health clinics and hospitals; take back or redistribute any that are overstocked, and destroy or retest for possible further use those that might be expired.
59. CMS should inform the two Ministries, in advance, of the costs of drugs, FP items and other medical supplies distributed to their facilities.
60. This draft regulation should be withheld until more study has been made into its possible negative effects on OC usage. It is further recommended that OC refills be available to users in private pharmacies without the need for new prescriptions/consultations.
61. The CMS, in close consultation with the Drugs Unit of MOH, should be able to purchase on tender those items it considers cost/efficient for the national health service, whether registered in Botswana or not, as long as quality is not compromised. Suppliers of such items should have to demonstrate approval for good manufacturing practices in their countries of origin and ability to carry out any possible orders within the required period of time. They should be urged to produce registration documentation and materials at an early stage to be evaluated by CMS and MOH Drugs Unit before confirmation of orders.

The evaluation team attempted to gather data on end-of-year stock levels in health facilities for the period 1988-1995. These data, when factored from quantities of stock distributed by CMS, would have yielded a better estimate of contraceptives actually distributed by health services centers. However, data on end-of-year stock levels were not available except for 1994-95.

See section 3.3.

NORPLANT² trials in Gaborone include some 1,000 clients at present. This method could become quite popular among clients in urban areas with sufficient numbers of specially trained providers.

In August 1994 the MIS advisor, Cliff Olson, and the project chief of party visited CMS. It was found that CMS had decided to abandon the MIS software inventory system, and negotiations were under way to contract for a South African software system. A visit to the central MOH also revealed that an expatriate advisor was placed under the Norwegian Agency for Development Cooperation (NORAD) with responsibility for technical support services. The Cambridge Consulting Corporation team therefore decided to back off from the assignment to revise the CMS inventory and

tics systems. This was reported to USAID and the PFHO, FHD, and MOH. In a recent conversation with CMS it was noted that they have already developed another software and they plan to produce the new types of reports in October 1996.

The recommended new initiative IS NOT A REPLACEMENT FOR OTHER ACTIONS discussed and recommended in this section or elsewhere in this report. Rather, it is an additional, complementary initiative which can provide a living laboratory in which to test new strategies and approaches to outreach and service delivery.

APPENDIX E

Management Information System for MCH/FP: The Future After BOTSPA

Despite several years of assistance from the BOTSPA project and from UNFPA, the MCH/FP management information system needs to be strengthened further if an effective and rational MCH/FP service is to be achieved and sustained:

1. More MCH/FP providers in health facilities need to be trained in the proper use and significance of the MIS including Logistics, as do members of District Health Teams
2. MIS Handbooks and Revised Logistics Management Manuals need to be printed, distributed and used as soon as possible.
3. The MIS report forms need some revision and refinement but the present system is basically adequate and should not be made more complicated or time-consuming.
4. The reported information needs to include data on contraceptive consumption and requisitions.
5. The incoming data needs to be delivered faster to the MCH/FP Research and Evaluation Unit who need to process it more promptly in a more digestible form for MCH/FP management, at least once a quarter.
6. The processed and analyzed data need to be sent back promptly and efficiently to District Health Teams and the health providers; these need also to be informed of costs of supplies of MCH/FP items including contraceptives, STD drugs, etc.
7. CMS needs to be informed promptly by the MCH/FP R & E Unit of consumption figures of contraceptives and STD drugs used in MCH/FP facilities.
8. The MCH/FP R & E Unit needs to be strengthened by at least one more technician (research statistician), and the present management needs strengthening. It also needs to have its goals and objectives clarified by MCH/FP management.
9. Central Medical Stores (CMS) needs to inform MCH/FP R & E Unit of FP deliveries to districts, monthly. This information, costed out, needs to go back promptly to District Health Teams.
10. UNFPA may wish to consider more support towards the strengthening of the MCH/FP MIS system on the lines suggested above. Such support could include technical personnel and training, systems development, etc.

APPENDIX F

PRINT MATERIALS ON FP/STDs

Following is a summary of print materials on FP/STDs that are currently available from the MOH Health Education Unit:

- ? Materials for low-literate audiences. The HEU continues to distribute the three Setswana booklets on contraceptive methods, pill use, and condom use. These booklets were developed in 1985 with PIACT technical assistance. MCH/FP staff plan to update and reissue them. Print materials on the IUD and injection are not available. No audio-visual materials on contraceptive methods have been developed in Setswana.
- ? Materials for youth. Five photonovelas for youth have been produced; three of them were produced under the BOTSPA project. They are popular among youth; roughly 15,000 of each were distributed in the past year. HEU also produced two Setswana posters for youth: "Teens start life well by practicing family planning" and "Because we care about each other, we use a condom." Under the BOTSPA project, PSI also produced some print materials for youth and sponsored a weekly radio program.
- ? Materials for males. Two booklets on contraceptive methods have photos of couples on their covers and thus are used to explain family planning to men. One, "The Reasons for Family Planning," requires basic reading skills in Setswana. The other, "What is the Best Method for you and your Partner?" provides basic information on contraceptive methods but requires a fairly sophisticated knowledge of medical terms. Produced in English and Setswana, it discusses prevention of STDs and HIV/AIDS only in relation to condom use. Roughly 10,000 copies of each are distributed annually.
- ? Materials to support client counseling. Service providers lack simple materials to explain the possible side effects and danger signs to new users. The fact sheets on pills, injections, and IUDs mentioned in the 1992 PP Supplement would be useful. PSI's packaging for Lovers' Plus can be considered to meet the need for information on condom use. A leaflet on NORPLANT[?] use was developed by MCH/FP and HEU for use in the NORPLANT[?] pilot project.
- ? Materials for service providers and community educators. The booklet "Family Planning: What People Need to Know," which was produced by the HEU in 1985, was designed to provide basic information on family planning

for extension workers, teachers, and other development workers. Written in English, it is appropriate for highly literate audiences. Most FWEs, who have two years' education beyond primary school, would probably have a difficult time reading it and understanding the concepts. A family planning flip chart was produced in English and Setswana in about 1985. It is out of print but could be redone in a smaller, lighter version for community outreach.

- ? General promotion of family planning. A wallchart listing contraceptive methods and their advantages and disadvantages is available in English and Setswana. It was spotted in several clinics during field visits.
- ? STD diagnosis, treatment and prevention. Although the BOTSPA Project did not produce any booklets on STDs, two booklets in Setswana were developed by HEU and the AIDS/STD Unit/AIDS Action Trust, respectively, during 1995-1996.

APPENDIX G

Botswana Social Marketing Program (BSMP)

The Botswana Social Marketing Program for HIV/AIDS prevention appears to have achieved its logistics objectives under the BOTSPA program. Sales of condoms exceeded the targeted number and continue at a substantial level mid-way through 1996, though there is an indication of some plateauing at the 1995 level (2 million condoms). This may be due to a possible saturation of the market as well as the impact of free condoms available in substantial quantities in health facilities.

The strength of the BSMP is that its condoms are now widely available and affordable at a basic outlet level where they are needed most. In addition, the condoms are very accessible to groups that might be particularly vulnerable to HIV infections, such as young males, who might not wish to ask for condoms at health facilities or in pharmacies.

Now that the BSMP condom Lovers Plus is widely available, and the logistics system is functioning satisfactorily through the well-organized distribution of the largest wholesaler in Botswana Ya Rona, the need still remains for condoms to be used when necessary, and for potential HIV risk behavior to be minimized. A continuation and intensification of HIV-prevention counseling and promotion of condom use is seen as indispensable for the national campaign against the high rate of HIV transmission.

The BSMP is seen therefore as a significant support to the national program against AIDS as well as a tool towards better reproductive health and FP. With the withdrawal of funding under the BOTSPA program, however, new ways must be found to sustain the BSMP.

Presently, BSMP is able to continue its activities for one year, until April 1997, under a grant from the Government of Botswana for \$ 242,000 in combination with free contraceptive supplies from Central Medical Stores.

Several suggestions have been made in the BSMP evaluation above (section 4) as to how the BSMP could make itself more financially self-sustaining, particularly in the event that GOB financial support is not forthcoming after April 1997. It is estimated that the minimum level of funding/revenues necessary for BSMP to continue its important HIV prevention activities and better reproductive health promotion would be \$ 120,000/year, at present price levels and exchange rates.

As discussed above, if Government of Botswana financial support is withdrawn in 1997/98, this amount may come from: a) raising the price of the Lovers Plus condom to a public price of Pula 1.-/pack of 3, b) doubling the present level of sales, c) possibly launching a new

premium, more profitable brand, or d) a combination of all three.

However, at this lower level of funding, there would have to be considerable rationalizations in staff numbers (down to 5-6 from 23), more use of national service personnel as peer educators, and some downsizing in advertising and promotion activities. The project could not support the costs of another expatriate adviser from PSI/Washington. Also, the project could not survive without the continued supply of free condoms through the Central Medical Stores, though measures may be considered to reduce the relatively high purchase price of these condoms, such as buying in bulk and local re-packaging.

At a funding level of \$ 120,000/per annum + a supply of free condoms, the BSMP could achieve a CYP of some \$ 9, a much more cost/efficient ratio than the present one under the Botspa project of over \$ 50, and more in line with other established social marketing programs in Africa.

However, it is clear that the HIV/AIDS epidemic in Botswana is alarming; transmission rates of HIV and STD²s continues to be high. Obviously, the more funds for social marketing that are available, the more HIV-prevention activities can be carried out, and the better prospects there are for reducing the high transmission rates which will have important social and economic benefits for the country. As long as the Government of Botswana²'s financing permits, therefore, it may be appropriate to continue the 1996/97 level of GOB funding support through 1997/98 and on through to the end of the decade.

During this period, the BSMP, by studying the cost/benefits of rationalizations and new activities as mentioned above, should endeavor to be totally self-sustaining and an integral part of national anti-HIV/AIDS activities, as well as an important element of reproductive health/FP promotion.

Appendix H

NGOS - PLANNED AND ACHIEVED OUTPUT

1. *Identification of managerial problems facing NGOs involved in reproductive health care provision* - achieved
2. *Increased NGO efficiency and effectiveness* - not achieved. Project duration too short to achieve this output.
3. *Enabling NGOs to identify and test solutions to service delivery problems* - partially achieved. Eight NGOs identified research topics based on problems faced.
4. *At least 20 NGO representatives familiar with BOTSPA NGO Project* - achieved.
5. *Team spirit existing among participating NGOs* - partially achieved. Top-level management not supporting junior staff to implement what they learned.
6. *A summary of proceedings of Project Identification Workshop existing in NGO offices (6)* - achieved. Existed in nine NGOs visited by the Evaluation Team.
7. *At least six NGOs utilizing the Needs Assessment Report as a planning tool* - partially achieved. The report utilized as a basis for determining the content of the three management workshops organized.
8. *Technical Assistance Plan existing in six NGOs developed by BNPC/HRU* - partially achieved. TA plans were developed but no TA was provided.
9. *TA provided to at least six NGOs* - not achieved.
10. *Ability of some staff in the six NGOs to monitor and evaluate projects* - not achieved.
11. *Tools for effective supervision of projects existing in NGO offices* - not achieved.
12. *Utilization of the tools for effective supervision* - not achieved.
13. *Knowledge and skills existing among some NGO staff on personnel motivation* - achieved.
14. *Interest in financial management for non-account staff of NGOs who participated in the workshop* - not achieved.
15. *At least six NGOs managed by objectives* - not achieved.
16. *Strong negotiation skills existing in at least six NGOs* - partially achieved. Some of the staff trained by BNPC have initiated negotiations for change in management and for the development of strategic plans.
17. *At least six NGOs are able to develop strategic plans* - partially achieved. Nine NGOs visited did not feel confident to develop strategic plans on their own although they felt that they acquired some knowledge and skills through the workshops.
18. *Strategic plans (for 3-5 years) exist in at least six NGOs* - not achieved. Time was a constraint. Only two of nine interviewed had strategic plans. These were developed prior to attending the BOTSPA courses.
19. *Proposal development for pilot operations research project in at least six NGOs* - achieved. Eight of eleven NGOs participating in the BOTSPA Project were working on Operations Research projects (five proposals were developed).
20. *Technical Assistance provided by HRU and BNPC to at least six NGOs in implementing pilot operations research projects* - achieved. Four HRU staff assisted eight NGOs to plan and implement OR projects.
21. *A final report on operations research project findings* - not achieved. Workshop for

- analysis and report writing planned for August 1996.
22. *At least six NGOs utilizing strategic plans to mobilize resources from local and international donors* - not achieved. Strategic plans not developed.
 23. *Findings of the OR projects utilized to form the design of larger service delivery efforts making reproductive health services more readily available to youth* - not achieved.
 24. *A baseline survey report for the NGO-strengthening Project* - achieved. Needs Assessment Workshop produced a baseline report.
 25. *Indicators for measuring success and progress developed* - not achieved.
 26. *A report on followup to the baseline survey developed* - achieved. Three workshops were organized as a followup to the baseline findings; reports on the workshops existed in nine NGOs.
 27. *Improvements in management at NGO level* - not achieved. Improvements reported by a few individuals who attended the workshop. These included time management and assertiveness, but no impact was reported at the organizational level.
 28. *Beginning of behavior changes in at least six NGOs, especially in management and service delivery* - partially achieved. Limited behavior change among staff who attended the workshops, but no change was reported in service delivery, and the project had very little impact on increasing reproductive health activities.

Members of Botswana Network of AIDS Service Organizations (BONASO)

Botswana Council of Women (BCU)
 Association of Medical Missions of Botswana (AMMB)
 Holy Cross Hospice
 Tirisanyo Catholic Church
 Ramotswa Hospice at Home (BLH)
 Young Women's Christian Association (YWCA)
 Gareng Ga Dithaba Theater Group
 Reetsanang Association of Community Drama Groups
 Corporation for Research, Development and Education (CORBE)
 Botswana Federation of Trade Unions
 Botswana Christian Council (BCC)
 Barclay's Bank of Botswana Ltd.
 Women and the Law in Southern Africa/Botswana
 Social Work Students Against AIDS
 Nurses Association of Botswana
 Metlhaetsile Women's Information Center
 Emang Basadi Women's Association
 AIDS Action Trust (ACT)
 Association of Teachers Against AIDS (ATTA)
 Botswana Family Welfare Association (BOFWA)
 PSI
 Botswana Red Cross Society

Participation of NGOs in Management Training Workshops (number of participants)

| NGO | KICK-OFF WORKSHOP | PRFORM. WORKSHOP | MGMT. RETREAT | STRAT. MGMT. | MGMT. CHANGE | TOTAL |
|-------------------------------------|----------------------|---------------------|------------------|-----------------|-----------------|-------|
| AIDS Action Trust | 2 | 1 | 4 | - | 1 | 8 |
| Botswana Council of NGOs (BOCONGO) | 1 | - | 1 | - | - | 2 |
| Botswana Family Welfare Association | 3 | 1 | 3 | 1 | 2 | 10 |
| Botswana Girl Guides Association | 4 | 4 | - | 5 | 3 | 16 |
| Botswana Red Cross Society | 4 | 2 | 14 | 2 | 2 | 24 |
| Botswana Scouts Association | 3 | 8 | 9 | 2 | 2 | 24 |
| Botswana Youth Centre | 2 | 2 | 11 | 2 | 2 | 19 |
| Cooperation for Research | 2 | - | - | - | - | 2 |

APPENDIX H - NGOs

| | | | | | | |
|--|----|----|----|----|----|-----|
| Development & Education | | | | | | |
| Mambo Arts Commune | 4 | 2 | 19 | 2 | 2 | 29 |
| Metlhaetsile Women's Information Centre | 1 | - | - | - | - | 1 |
| PSI/Botswana | 3 | 2 | 19 | 2 | 3 | 29 |
| Young Women's Christian Association | 3 | - | 7 | 3 | 9 | 22 |
| Association of Medical Missions for Botswana | - | 3 | - | - | 2 | 5 |
| TOTAL | 32 | 25 | 87 | 19 | 28 | 191 |

Operations Research Topics by NGOs

| | TOPIC | NGO | STATUS |
|---|---|-------------------|---|
| 1 | Accessibility, Availability and Use of Condoms Among Youth (15-24 Years) | BSA and BYC | Approved by Population Council |
| 2 | Utilization of Information, Education and Communication Material on HIV/AIDS by Adolescents with Disabilities | PSI AND RED CROSS | Awaiting Population Council Approval |
| 3 | Effectiveness of Peer Education Training Program in Gaborone | BOFWA and YWCA | Data collection completed. Data analysis to start in July |
| 4 | The Coverage and Adequacy of Services Provided by Association of Medical Missions for Botswana (AMMB) | AMMB | Data collection is on-going |
| 5 | Establishment of a Database and Developing Maps on NGOs in Botswana | BOCONGO | In progress |

A NEW DISTRICT-LEVEL INITIATIVE

Botswana Reproductive Health Action Program (BRHAP)

Purpose: To demonstrate a dramatic success in reproductive health service delivery, including family planning and AIDS/STD prevention.

Illustrative Goal: To raise contraceptive prevalence by at least 100% in one district in one year, with accompanying benefits to help interrupt HIV transmission among residents of that district.

Design Parameters: This initiative should...

- ? utilize and build on existing infrastructure and staffing
- ? demonstrate the interdependency of key elements in RH service delivery, including:
 - ? clinic-based services
 - ? outreach, including use of NGOs and private sector
 - ? IEC, especially for providers and clients
 - ? logistics and MIS
 - ? operations research
 - ? strategic and operational planning
 - ? effective, targeted training
 - ? local government involvement and support
 - ? national government involvement and support
- ? be planned and implemented on a scale large enough to:
 - ? attract local and national-level political attention
 - ? demonstrate:
 - technical feasibility
 - administrative and managerial feasibility
 - dramatic program impact
 - sustainability
 - scalability and replicability
 - ? attract resources, both national and donor

APPENDIX I

Financing and Sustainability After BOTSPA

Financing and sustainability of MCH/FP services, and closely associated with them, HIV/AIDS prevention, as key elements towards better reproductive health, will need close study at the close of the USAID-funded BOTSPA project. In the absence of donors to fill the financing gap, and assuming increasing financial constraints facing the Government of Botswana, the need to look for rationalizations and operating efficiencies in MCH/FP system appears critical.

This should not be looked at in isolation, however, but as one element of the GOB's efforts to maintain a functioning and satisfactory public health service within available resources. MCH/FP and HIV/AIDS prevention are major components of public health service, and any rationalizations and restructuring accomplished in those services should be reflected throughout the public health system.

Rationalizations - Reducing Costs, Raising Revenues

Rationalizations can be approached from two sides: reducing costs, and increasing revenues. Both imply, and have to be accompanied by, good management practices.

Reducing Costs

Reducing costs implies, among others, better training at all levels in clinical services, management, and in use of management information systems. It implies more rational treatment practices, prescribing of drugs, more use of generics, and more cost/efficient purchasing and supply systems. It implies better logistics management at all levels, MOH MCH/FP, CMS, District Health Teams, Health Facilities, and more rational inventory levels.

Recurrent costs of health have increased from Pula 132,4 million in FY 92/93 to Pula 279.8 million in FY 96/97, an increase over four years of more than 200% or 50% a year. Unless public funds are unlimited, obviously this level of increase cannot be sustained; cost per capita per annum now runs at Pula 200.

Central Medical Stores' budgets for drugs, dressings, medical supplies and equipment alone have increased from Pula 16 million in 91/92 to Pula 51 million in 96/97, which show a similar level of increase. The population has, however, only increased over the same period at an average rate of 3.5% per annum. What is happening therefore is that amounts spent on

providing health services, with costs of drugs and dressings accounting for a major part, are rising far faster than population growth.

Programs to train health providers in more rational prescribing and use of drugs, combined with more use of generics and generic purchasing, have been found in other countries to have reduced overall cost of drugs by some 40-50%, without affecting quality or service. It appears that certain economies will have to be considered by the GOB if present system of (virtually) free health service, including MCH/FP and HIV prevention, is to be sustained.

Included in this could well be studies into how Botswana Social Marketing Program (counseling, information, education and provision of low-cost condoms) could be maintained on its own revenues, without funding from the GOB. Condom supplies should, however, continue to be provided free from government (CMS).

Raising Revenues

A second option towards achieving financial sustainability would be raise revenues from health system users, i.e., patients, either directly in form of increased fees for treatment, or indirectly through taxation, levies etc.

This option has been under active consideration by the GOB over several years, and an assessment of policy options was carried out by Ministry of Health with assistance of International Health Policy Program, Washington, USA in 1991.

The present fee of Pula 2 per initial outpatient treatment (further contacts for same treatment are not charged) and per initial MCH/FP consultation -- which in practice appears to be often waived -- covered, in 1991, only 8% of public expenditure on health (ref: Cost Recovery in Botswana Health Sector, Oct. 1991). That percentage will have decreased considerably in the meantime.

Taking into account inflation since 1991, it would appear timely to increase the level of outpatient charges to a level which reflects more closely value of treatment provided, as well as make a modest prescription charge. In-patient charges could be similarly studied. If out-patient charges were increased to, say, Pula 5 per initial contact, at estimated level of outpatient contacts of around 4 million a year, some 20 million Pula a year could be recovered, which is 50% of CMS total purchasing budget for FY 96/97.

This matter should be closely studied, however, to take into account necessary exemptions (e.g., very poor, chronically sick, etc.) as well as average household incomes. Increases might be

applied by stages, rather than abruptly, and should be accompanied by sensitizing messages to public. Because of importance of not raising barriers to MCH/FP and HIV/AIDS prevention at this stage at least, probably the present level of Pula 2 er initial consultation should be maintained.

Summary

It would appear essential, in order to maintain and sustain an effective public health service, including MCH/FP and HIV/AIDS prevention, that the GOB considers measures to: (1) restrain expenditure growth; and (2) increase revenues in public health system. The suggestions above may be useful in consideration of appropriate measures; further studies are no doubt necessary; however, actions appear urgent.

BRHAP - Critical Elements

- ? **Leadership** --this is most critical, and should determine choice of District
- ? **Locally-based planning** -- with MOH, MLGLH participation
- ? **Local leader involvement** -- provide support and political umbrella
- ? **Clear focus and objectives** --need to avoid at all costs temptation to overload workers and over complicate project design
- ? **Detailed implementation plan** covering:
 - ? geographic focus and phasing, including mapping
 - ? specific service components
 - ? specific IEC interventions and materials
 - ? manpower availability and deployment
 - ? supplies and logistics
 - ? training, specific to tasks to be carried out
 - ? operations research components
 - ? command, control, supervision system
 - ? transport, including supervisor's needs
 - ? inter-agency coordination: government, NGO, private sector

Recommended service package and locus of operation:

FWEs, possibly assisted by other categories of personnel, would visit house-to-house on a near 100% coverage basis, making a complete round of assigned houses in a 3-month period. They would take a short survey at each visit, provide counseling in family planning and AIDS/STD prevention, and would offer orals and condoms at the doorstep. Referral cards for IUD, VSC, and injectables would also be provided for clients to present at their nearest health clinic or hospital.

NGOs would be responsible for providing IEC, family planning and AIDS/STD counseling, condoms, and referrals to clinics for groups not likely to be covered by the fixed infrastructure or by home visiting, especially youth and men. They would cover clubs, youth centers, schools, etc.

? **Mobile Stops?** could be organized to maximize utilization of, e.g., injectables and possibly IUDs, as well as STD counseling and treatment, with outreach workers (FWEs and NGO) directing potential clients to specific locations at predetermined dates.

BRHAP PROJECT SUMMARY

The objectives of the project are to:

1. To increase contraceptive prevalence by at least 100 percent in one district to be selected.
2. To reduce the rate of STD/HIV/AIDS infection among the population in the selected district.

Project Strategy

The strategy proposed calls for Family Welfare Educators through the Ministry of Local Government to reach all sexually active individuals in the reproductive age-group to provide them with pills, condoms, IEC materials and basic counseling on FP/STD/HIV/AIDS. This would be done through a directed program of systematic house-to-house visits designed to cover an entire population at least once every three months for a one-year period. FWEs would refer clients for service they (FWEs) do not provide such as IUD, Norplant, injectables, and VSC. They would also refer people with AIDS to health facilities or home based care centers.

Lessons learned previously show that youth and men are difficult to find at home, therefore, door-to-door service delivery would not likely bring them into the FP/STD/HIV/AIDS program. The NGOs and the private sector (the employers) would therefore complement the effort of the Local Government (FWEs) by providing FP/STD/HIV/AIDS services to youth and to men.

The youth in the district would be reached through youth clubs, schools, youth centers, cinema houses, market place, etc. Youth peer educator programs operated by NGOs would incorporate

IEC material and condom distribution as one of the program activities. FP/STD/HIV/AIDS counseling would become integral part of youth peer educators' work. Demonstration clinics to cater for youth reproductive health services would be established which would also serve as referral centers. It would be desirable to have a youth club, physical fitness center, library and a social hall, as annexes to the youth clinic to attract the youth. Debates, drama festivals, film shows, art exhibitions, etc. are examples of activities which could take place in the social hall to draw youth crowds.

Currently there are approximately 22 NGOs involved in AIDS prevention activities in Botswana of which at least 10 target the youth. At least seven out of the ten NGOs which participated in the Population Council's Operations Research Project under BOTSPA Project targeted the youth. PSI, YWCA and BOFWA take the lead through their peer education programs for youth. Others such as the Boy Scouts, Girl Guides Association and the Red Cross Blood Donor Programme work with large numbers of young people. Their participation in the proposed new initiative program at district level would impact on youth.

The Employers Contribution

Many of the NGOs, private sector and Government officials interviewed during the BOTSPA evaluation emphasized that men are mostly found at the work place.

It is proposed that as many employers as possible in the demonstration district should be mobilized to participate in the project to ensure more men are reached with FP/STD/HIV/AIDS, counseling and IEC for behavior change (BCC), and condoms.

Employers (in the district likely to be chosen) already providing FP services only should be encouraged to add STD/HIV/AIDS component. Where only STD/HIV/AIDS prevention activities are provided, FP should be added. Work sites which participate eventually join the proposed project would have to determine the maximum number of workers which each peer educator should effectively cover. Subsequently each work site should ensure that its number of peer educators match the number of employees, and a system should then be put in place which will ensure that as many employees as possible are reached by the peer educator/worker educator and distributor. Work place peer educators should distribute pills, condoms, IEC materials, provide basic counseling and refer clients for other FP methods. Referral of people with AIDS and worried well to health care facilities and home based care should also be part of the duties of the peer educators. Success in implementing a project of this nature at the work place would require support from the company management. The support should be demonstrated in practical terms by actions such as realizing employees from work to attend educational talks

or watch an educational video. Each work site would have its own work based supervisor/s. Peer educator who performs well could be considered to supervise the other peer educators.

Mobile Clinics

Utilization of mobile clinics to provide outreach services to special groups (i.e. youth/men/disabled) who are not reached by the FWEs, NGOs and the private sector could be another alternative approach to outreach services in the demonstration district.

Modalities for Implementation

1. Team Building for the New Reproductive Health Initiative

For the above proposal to work, intensive planning and concerted efforts from the Ministry of Health, Local Government, NGOs, Private Sector, Trade Union would be mandatory. A team of representatives from these organizations, should form a committee and co-op a researcher (for Operations Research) a trainer and a planner into their committee. The convener of the committee meetings should be the matron.

NGOs and employers particularly in the project should establish their own team/committee to play advocacy role for the new reproductive health initiative.

2. Investing FP/STD/HIV/AIDS skills in CBD Workers (FWEs, Peer Educators)

a) It is proposed that co-trainers and personnel who will supervise the CBD workers (especially FWEs) should be identified and refreshed on training and supervision of CBD workers in the context of the new Reproductive Health initiatives.

3. Refresher Courses

FWEs and other CBD workers should receive training (initial and refresher) on skills they require to conduct CBD work. Those who had been trained should be refreshed. The course content should include but not be committed to the following FP/STD/HIV/AIDS package; counseling and IEC for behavioral change (BCC), condom promotion and distribution; distribution of IEC materials, record keeping, reporting contraceptive logistics and management, referral procedures and delivery of integrated FP/STD/HIV/AIDS messages.

4. Mobilizing the Employers and the Unions to Support the Project

Sensitization seminars should be organized for the employers, and trade unions to solicit their support and trade unions and participation in the project.

5. Mobilizing NGOs to Participate

Seminars should be organized for the NGOs to share the vision of the new Reproductive Health initiatives. Interested NGOs should be encouraged to participate and to support the project. The NGOs would utilize their staff, condom dispensers, pharmacies, chemists, peer educators, mobile and special clinics to reach the youth and men with FP/STD/HIV/AIDS services.

Initiation of special clinics for youth and mobile clinics to provide out-reach services would be necessary. Incorporating as many peer educators as possible to the new initiatives project to provide counseling services for behavior change would be a strategy to empower the youth. Youth peer educators should also distribute condoms to their peers. Establishment of youth clubs by NGOs would go a long way in mobilizing the youth to participate in the new initiatives project. The clubs would provide recreational facilities, health clubs and training facilities for peer educators. FP/STD/HIV/AIDS clinics for young people should be part of the club complex.

Mobile clinics/cinemas should be introduced to take clinical and IEC services to the areas with no youth clubs.

6. Capacity Building

Management and supervisory staff of the participating NGOs, the private sector and Local Government Ministry would require orientation on management, monitoring and evaluation of the demonstration project. The orientation course should include topics such as communication, coordination and resource allocation to ensure effective implementation of the project.

The capacity building exercise should focus on unifying and streamlining management and supervisory procedures, to standardizing them (especially among the NGOs). Currently at least three peer educator training manuals exist. There should only be one).

7. Supervision

FWEs

FWEs should be supervised by the clinic nurse assisted by a senior FWE. If possible, a position should be created for Principal FWEs who would serve as immediate supervisors of FWEs. She would report to the clinic nurse. Considering the fact that when FWEs are removed from the clinic to the Community, the nurse, who is the FWEs supervisor is likely to have increased work load and, therefore, would not find time to supervise FWEs.

Each work site participating in the project should establish its own supervisory system to give recognition and support to its Peer Educators and ensure long term sustainability of the project

NGOs should supervise peer educators working under their umbrella. Local Government clinics based staff should supervise their mobile clinic teams.

Technical Support for the CBD Project

Local Government clinic staff or mobile clinic teams should support the CBD workers by supplying them with contraceptives and IEC materials.

Technical support in contraceptive logistics particularly in preparing contraceptive procurement tables and establishing yearly contraceptive requirements for each clinic and CBDs, and work sites would be an important requirement for the project.

8. Leadership

Local leadership particularly from the implementing Ministry (Local Government). A dynamic matron who is able to conceptualize the project with a vision. This would be the most important requirement for this project. She would mobilize policy and political support from the local community (village health committees and village development committees), politicians, etc. She would work closely with Ministry of Health as an equal partner in the project.

Other critical requirements would include political good will, manpower and other resources, (e.g., transport for supervisors).

FWE/Peer Educator Incentive Scheme

Motivation and incentive scheme would be established to retain the CBD workers in employment, and motivate them to perform better.

Some suggestion are provided below on what might be considered in developing an incentive

scheme for CBD workers such as FWEs, NGO Based Peer Educators and Work Place Peer Educators:

1. Organizing regular refresher courses to up-date their knowledge and skills, and to provide an opportunity for the CBD workers to exchange ideas and learn from each other.
2. Providing feedback to CBD workers by their supervisors and vice-versa. Monthly meeting for CBD workers to review progress and plan for the following month would be useful.

Job descriptions of CBD workers should not only be standardized but should be detailed to include (but not be limited to) the following activities:

- ? conducting household surveys at the initiation stage of the demonstration project to know every household in his/her area of operation and their health problems, including contraceptive/condom use, attitudes towards family planning and STD/HIV/AIDS, etc.;
- ? visiting each household every three months for one year to initiate or re-supply contraceptives (pills/condoms) and provide counseling services;
- ? prepare a map of the villages covered and draw a work plan for household visits;
- ? provide the services already outlined in this report.
- ? Award to the best CBD worker. Criteria for selecting the best CBD worker should be developed by the CBD supervisors in collaboration with the CBDs;
- ? Exchange visits among CBD workers, to learn from each other;
- ? Provision of bags carrying IEC materials and contraceptives. Other incentives could include providing the CBDs with diaries and calculators.
- ? Job grades for paid CBD workers so that upward mobility for CBDs who perform well is possible.
- ? Recognition of CBD workers by Local Government, Ministry of Health, NGOs and

Management of various employers, for example, Principal FWE in charge of other CBD workers could be invited by the management periodically to give a report on the project.